STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235538	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT HEALTH CAMPUS OF JACKSON	703 ROBINSON RD JACKSON, MI 49203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to monitor and maintain current Guardianship documentation for 1 of 3 Residents reviewed (Resident #47), resulting in expired guardianship documentation. Findings Include: Resident #47 (R47) R47 was observed in her room on [DATE] at 04:15 PM sitting up in a recliner, cleanly dressed and groomed watching TV. When conversation was attempted, R47 spoke softly, however writer was unable to understand what was attempted to be said. On [DATE] at 02:40 PM the Electronic Medical Record (EMR) for R47 was reviewed and reflected she was originally admitted to the facility on [DATE], went out the hospital on [DATE] related to a fall and readmitted on [DATE]. R47's significant change Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date (ARD) of [DATE] reflected R47 had severe cognitive impairment, required supervision of 2 persons to transfer, and extensive assistance of 1 person for dressing, toilet use, hygiene and bathing. R47 annual MDS with an ARD of [DATE] reflected R47 had severe cognitive impairment, independent with supervision to transfer, supervision of 1 person for toilet use, and extensive assistance of 1 person for hygiene and bathing. On [DATE] at 02:42 PM, the EMR reflected R47's brother/family member had only had temporary delegation of powers or guardian consent for medical care. The document reflected a start date of [DATE], and expiration date of [DATE]. On [DATE] at 10:28 AM the facility's Social Worker (SW F) was interviewed. SW F revealed R47's brother (Brother S) was her guardian. When asked where was R47 current guardianship documents, SW F was unable to locate it in the EMR, or the binder book she kept guardianship documents. SW F revealed she did not know where the current guardianship documents were, and that the facility was supposed to have a copy of it. However, a copy of the current document was not on site at the facility. Later the same day at 11:09 AM SW F revealed she planed to email (Brother S) for a copy of R47's current guardianship paperwork, and at 11:47 AM the Administrator (ADM A) apologized for not having the requested documentation. On [DATE] at 02:06 PM, after writer discovery the below note was reviewed in R47's EMR: [DATE] 11:33 Found guardianship paperwork in Matrix to be expired in 2018. Called (Brother S) and asked for updated guardian order. (Brother S) states he never got one in the mail. I asked him to go to the courthouse and request a copy of the newest guardianship order showing him as guardian. (Brother S) says he will do that and he will bring it in next week along with his payment.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the resident/resident representative in writing of a discharge/transfer to a local hospital, for Resident #47, resulting in the potential for the resident/resident representative to be mis-informed of events that occurred causing the transfer and residents options for maintaining occupancy at the facility. Findings Include: Resident #47 R47 was observed in her room on 08/25/20 at 04:15 PM sitting up in a recliner, cleanly dressed and groomed watching TV. When conversation was attempted, R47 spoke softly, however writer was unable to understand what was attempted to be said. On 08/27/20 at 02:40 PM the Electronic Medical Record (EMR) for R47 was reviewed and reflected she was originally admitted to the facility on [DATE], went out the hospital on [DATE] related to a fall and readmitted on [DATE]. R47's significant change Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date (ARD) of 7/1/20 reflected R47 had severe cognitive impairment, required supervision of 2 persons to transfer, and extensive assistance of 1 person for dressing, toilet use, hygiene and bathing. R47 annual MDS with an ARD of 4/15/20 reflected R47 had severe cognitive impairment, independent with supervision to transfer, supervision of 1 person for toilet use, and extensive assistance of 1 person for hygiene and bathing. When asked what were residents or their responsible party to receive upon discharge to a hospital on On 08/27/20 at 02:10 PM, Customer Service Administrative (CSA T) revealed the nurse should send a packet with the resident, and notify the family/resident representative by phone. When asked what the packet entailed CSA T revealed it contained the bed hold policy, but was not for certain of the other items. The Director of Nursing (DON B) was interviewed on 08/27/20 at 03:07 PM, and asked what documents were provided to residents when leaving the facility to go to a hospital. DON B revealed, a copy of the face sheet, critical care documents, copy of medication list, bed hold statement and a transfer event documented. Also, that in the progress notes there should be a note. Upon reviewing R47 EMR at that time, none of the above information was noted documented provided to R47 or her responsible party upon hospital transfer from 6/25/20 to current 8/27/20, nor was a transfer event noted. Registered Nurse (RN U) who transferred R47 to the hospital on [DATE] was queried about the discharge. RN U revealed R47 was sent out to a local hospital's emergency department. When asked what was sent with R47 RN U revealed, she knew the facility did not send a packet, but was sure she would have sent R47's face sheet and medications. RN U revealed she did not remember doing a transfer event for R47, and that there were a lot of things she was not familiar with. On 09/01/20 at 10:06 AM the EMR for R47 reflected no discharge documentation in the EMR, no documentation was available to reflect discharge documentation had been given to R47 or her responsible party in writing. A blank notice of transfer or discharge document dated 2020 was reviewed with items that reflected information that was needed and included the following: -Transferred or discharged to -Reason for transfer or discharge -Right to an impartial hearing -Ombudsman contact number -State Regulatory, Protection and Advocacy contact numbers -Information related to private pay -Medicaid Assistance -Michigan Medicaid
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** This citation includes Intake # MI 154. Based on observation, interview and record review the facility failed to A) document, assess and monitor a reported hand injury for Resident #11, B) implement new interventions to prevent falls for Resident #202, and C) prevent resident #152 from experiencing two witnessed and preventable falls, resulting in a bruise to the left hand, falls, the potential for major injury and the likelihood if re-injured fearfulness and mistrust towards facility staff. Findings Include: Resident #11(R11) During an interview on 08/26/20 at 10:18 AM with R11, his left hand was observed to have a dark purple/black colored bruise to the back of his hand/dorsal side visibly measuring at about 1.5

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

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) inches in length x .5 inches width. When asked what caused the bruise R11 revealed, he was in the shower room and while lifted with an electronic lift device his hand was squished and/or hit against the wall. When asked when the event occurred R11 revealed earlier in the week around Monday 8/23/20. On 08/27/20 at 10:25 AM, there was no change to R11's hand compared to 8/26/20. The Electronic Medical Record (EMR) on 08/27/20 at 03:35 PM for R11 reflected he was admitted on [DATE], and had [DIAGNOSES REDACTED]. R11's quarterly Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date of 6/3/20 and his annual MDS with an ARD of 3/5/20 reflected R11 was cognitively intact, required extensive assistance of 2 persons for bed mobility and transfers, required extensive assistance of 1-2 persons for toilet use and hygiene, and required extensive assistance of 1 person for dressing. On 08/27/20 at 04:25 PM Licensed Practical Nurse (LPN I) was asked if she was aware of R11's bruise to his left hand. LPN I revealed she was not, and would fill out an incident report. Also, that Certified Resident Care Assistants (CRCA's) would notify nursing staff if they saw issues to residents skin. LPN I was queried about R11's shower days, and looked in the units shower book which reflected R11's shower days as: today 8/27/20 Thursday's (after dinner preferred) and Monday's (preferred before dinner). When asked where the incident report for the bruise would be, LPN I revealed it would be listed as an event. LPN I then looked in the EMR under events, and revealed there was not an event for R11 related to his hand, and that she would create one. An event was then created by LPN I as a result of writer's discovery. CRCA P on 08/27/20 at 04:36 PM when asked if skin checks were done on bath/shower days revealed, they check the resident's skin and would tell the nurse about any abnormal areas, the nurse would then check the areas reported about, and the nurse would document. CRCA P also revealed, R11 was a sit to stand transfer (a electronic lift device designed to secure patients during transfers from a seated position to a standing position). The Director of Nursing (DON B) was interviewed on 08/28/20 at 09:41 AM, about R11's bruise to his left hand. DON B revealed they thought it occurred on Monday because the bruise was old. When interviewing staff, all denied being aware of the bruise to R11's hand. DON B revealed once the event was created, the incident investigated. Staff were interviewed who gave R11 a bath earlier in the week, and staff who did skin checks denied being aware of the bruise. R11's records in the EMR were reviewed 08/28/20 at 11:03 AM, and were negative for any entries/documentation related to the bruise on his left hand from 8/19/20 to 8/28/20. LPN I was interviewed again on 08/28/20 at 11:10 AM, and asked where did CRCA's document shower assessments. LPN I revealed, there was no assessment to document, they would tell the nurse, and in the Treatment Administration Record (TAR) there was an alert for each resident on shower day to do a weekly skin assessment. There was no alert or skin documentation reflecting an impairment on R11's shower day 8/24/20. Registered Nurse (RN R) was interviewed by phone on 09/01/20 at 10:36 AM. When asked if CRCA's did skin checks on shower day RN R revealed, they should always be looking at the skin. Nurses should be aware of residents skin, if there were issues out of the ordinary, CRCA's should alert the nurse, the nurse should take a look at it, and that skin assessments were done weekly. Also, that skin charting was done in the computer under treatment. RN R denied working with R11 on 8/24/20. LPN W was interviewed on 09/01/20 at 12:24 PM, and revealed she took care of R11 on Monday 8/24/20. When asked about skin checks LPN W revealed, on bath days CRCA's did skin assessments, if they saw anything abnormal they were to notify the nurse. When asked is she was aware of R11's bruise to his left hand, LPN W revealed it was reported to her by the night shift LPN X, and that she had asked LPN X is she had did an event. LPN W was asked to describe the bruise and revealed, it was a circular even bruise on his had and dark blue black in color. LPN W denied that any CRCA had reported any skin issues related to R11 on 8/24/20, and that skin assessments were put in the TAR on bath days with or without skin concerns. Again, the TAR for 8/24/20 was negative for a skin assessment. LPN X was interviewed on 09/01/20 at 01:01 PM, and revealed she worked and cared for R11 on Saturday 8/22/20 and Sunday 8/23/20. When asked if she recalled R11 having a bruise on his hand LPN X revealed, Yes it would have been Sunday morning before I left yes. Also, that she did not realize it was bruise, R11 tried to tell her about it, she had an aide go in R11's room with her to make out what he was saying, and that R11 said something about his hand got squeezed or squished between the lift when he was given a shower. Also, LPN X revealed, she did not write it down because she was not sure of what R11 was saying and that she only worked at the facility per diem. When asked what color was the bruise LPN X revealed, it was purple not dark, no definite boarders, and nothing looked bruised around it. LPN X estimated the bruise measured about 2 centimeters (cm) x 3 cm, and was oblong almost like an opal. LPN X was asked if she tried to find out was happened to cause the bruise. LPN X revealed, she did not know where to look to see where he got the shower, she was in R11's room a couple different times, and he only mentioned it one time to her. There was no documentation noted or provided by the facility prior to exit on 9/1/20 reflecting any monitoring of the bruise shape, size or color from 8/23/20 to 8/27/20, prior to sharing discovery with facility. Review of the medical record reflected that Resident #202 (R202) was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Via iPhone FaceTime observation on 8/26/2020 at 9:06 AM, R202 was observed in bed, eating breakfast. Dark bruising was observed around R202's right eye. Upon attempting to speak with R202, staff reported that R202 had some difficulty talking. During a phone interview on 8/26/2020 at 10:39 AM, Family Member (FM) D reported that R202 had two falls at the facility, with one resulting in a broken blood vessel in the right eye. FM D reported that R202 would try to get up to go to the bathroom. FM D reported that R202 had fallen twice at home, once in July 2020 and once in August 2020, due to trying to get up to go to the bathroom. Review of R202's Baseline Care Plan, with a completed date of 8/18/2020, reflected that R202 was not alert and oriented, had impaired daily decision making, dementia and short-term memory impairment. The Baseline Care Plan also reflected that R202 had [MEDICAL CONDITION] (language disorder affecting the ability to communicate) and difficulty making herself understood. The Baseline Care Plan reflected that R202 had bowel and bladder incontinence. Desired bowel and bladder approaches (interventions) for R202 included but were not limited to, Offer and toilet upon rising, before and after meals, and before bedtime. R202's Baseline Care Plan also reflected that they were at risk of falls or lacked safety awareness. History or observed triggers that were marked included but were not limited to, History of falls, Cognitive impairment that affects safety/judgment, History of or incontinence of bowel or bladder and Requires staff assistance and/or assistive devices for safe transfers and mobility. R202's Falls Care Plan, with a Problem Start Date of 8/17/2020 and a Created date of 8/26/2020, reflected that all interventions had an Approach Start Date of 8/17/2020 and a Created date of 8/26/2020. Interventions included: - Assure the floor is free of liquids and foreign objects. - Encourage/assist resident to assume a standing position slowly. - Keep call light in reach. - Keep personal items and frequently used items within reach. - Provide nonskid footwear. - Staff to assist Resident with transfers as needed - therapy eval (evaluate) and treat as needed. Review of an Event Report for an event date of 8/19/2020 at 12:38 PM and a completed date of 8/25/2020 at 7:03 PM, reflected that R202 had a fall in their room and was observed on the floor in front of a chair by staff. The chair was in the reclining position. The report reflected that R202 was self-transferring and ambulating just prior to the fall. There was no documentation of a root cause analysis for why R202 may have been self-transferring or ambulating. The section of the Event Report titled, NEW INTERVENTIONS - Immediate measures taken reflected, Toilet resident, evaluate continence. According to the Event Report, R202 complained of increased right hip pain, and a fracture was suspected. R202's medical record reflected they were sent to the emergency room for evaluation and treatment after the fall on 8/19/2020. According to R202's Progress Notes, all x-rays and CT scans in the hospital were negative. R202 returned to the facility at approximately 9:00 PM on 8/19/2020. A Progress Note for 8/21/2020 at 4:16 AM reflected that the sclera of R202's right eye was blood red, swollen and painful to touch. The note also reflected slight bruising noted around the eye and that the upper and lower lids appeared to have some swelling around them. The note reflected that Physician E was notified and gave new orders to apply ice to the eye, perform neurological checks and notify the physician of any further changes. According to a Progress Note for 8/21/2020 at 6:30 AM, R202 was sent to the emergency room for evaluation and treatment of [REDACTED]. A Progress Note for 8/21/2020 at 11:30 AM reflected that R202 returned to the facility with a [DIAGNOSES REDACTED]. According to an interview with Physician E on 8/27/2020 at 1:51 PM, it was assumed that R202 hit her head during her fall on 8/19/2020. Physician E reported that the Preseptal Hematoma was explainable due to the fall (on 8/19/2020) and R202's use of blood thinning medication. Review of an Event Report for an event date of 8/25/2020 at 6:42 PM and a completed date of 8/25/2020 at 6:59 PM, reflected that R202 was observed on the floor, in front of their recliner. The Event Report reflected that R202 was self-transferring just prior to the fall. The section of the Event Report titled, NEW INTERVENTIONS - Immediate measures taken reflected, Toilet resident, evaluate continence, Moved items for easy reach, describe - moved personal property closer to reach and Mat next to bed. R202's medical record reflected they were sent to the emergency room for evaluation and treatment after the fall on 8/25/2020. R202 returned to the facility the same day. During an interview on 8/27/2020 at 2:32 PM, Director of Nursing (DON) B reported that after R202's first fall, they put appropriate interventions in place for cognitive functioning. According to

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When asked if care plans were updated with interventions, DON B reported, yes and stated that should have been done at the same timeframe that the event was entered. On 8/28/2020 at 12:54 PM, an email request was sent to Nursing Home Administrator (NHA) A for R202's toileting documentation for 8/17/2020 to 8/26/2020. The information was not received prior to the survey exit on 9/1/2020. Resident #152 Resident #152 (R152) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. R152 was discharged from the facility on 12/1/19 when she was transferred to a local hospital following a fall at the facility. R152 had a brief interview for mental status (BIMS) score of 15 out of a possible 15 points indicating R152 had the ability to gain knowledge and problem-solve. According to the Minimum Data Set (MDS), dated [DATE], R152 was an extensive, two-person assist for bed mobility, transfers, dressing and toileting. When bathing, R152 was a 2 person, totally dependent assist. There was no other MDS to use as a comparison to determine if R152 had a decline in condition prior to her discharge to the local hospital. R152 was no longer in the facility. Fall #1: On 8/27/20, a record review of a complaint revealed that, during an attempt to transfer R152 by an Occupation Therapist (OT) M, R152 and OT M both fell on the floor. The complaint stated that OT M fell across R152. On 8/27/20, Administrator A was asked if R152 had a recent fall and to provide documentation of the investigation into that fall. Administrator A commented that all incidents are documented in the facility's electronic medical record (EMR). On 8/27/20, a record review of R152's EMR revealed that R152 fell twice between her admission on 9/11/19 and 1/27/20. A record review of the document titles Event Report, dated 10/20/19, indicated PT/OT staff was transferring (resident name) from her W/C (wheelchair) to chair in room. My knees gave out per resident. Staff eased resident to sitting position on floor. Documentation by OT M, who attempted to transfer R152, stated Pt seated in lift chair upon arrival. Transfer X 1 (one person) max (maximum) A (assist) from lift chair to w/c. Pt knees gave out during transfer. Pt sat on edge of chair but unable to get legs under and therapist (OT M) could not lift - control slide to floor with therapist (OT M) holding and stretch legs out. Pt c/o (complained) of pain in knees. Nursing called and physical therapist assistant (PTA L) able to place her in chair. An additional document in the investigation, signed by OT M and co-signed by the Program Director (PD N), stated Per our phone conversation on 10/21//19, I have been inservised (sp) on (title of education program) transfer policy regarding transfer recommendations, and where to find current transfer recommendations. I understand the importance of following transfer recommendations and will review transfer recommendations prior to beginning treatment and use the appropriate method. On 8/28/19 at 10:45 AM, Physical Therapy Assistant (PTA) L was interviewed. According to PTA L, when he entered R152's room he witnessed both R152 and OT M on the floor on their hands and knees. PTA L requested R152 to kneel straight up so he could grab her gait belt and then R152 was assisted into the lift chair. PTA L noted R152 had gripper socks on and R152 did complain of knee pain when she was assisted into the lift chair. PTA L noted that OT M was attempting to pivot transfer R152 into the wheelchair. On 8/28/20 at 11:00 AM, a voicemail was left for OT M, who attempted to transfer R152 which resulted in a fall. A second phone attempt was made at noon. By the end of the survey, there was no response from OT M. Fall #2: On 8/28/20, a record review of the investigation into R152's fall that occurred on 12/1/19 indicated Registered Nurse (RN) K and Certified Nursing Assistant (CENA) J were transferring R152 from her wheelchair to her bed using a Hoyer lift. When R152 was in the air next to her bed, RN K abandoned R152 and left the room in response to a call for help from a nurse in the next room leaving CENA J alone in the middle of a Hoyer transfer. CENA J pushed R152 over the top of the bed and had R152 centered with her head above the pillow when the sling above R152's right shoulder came off causing R152 to fall from approximately 12 inches from the sling to the bed landing on her right shoulder with the rest of her body still in the sling. When RN K returned to the room, R152 was lowered to the bed and assessed by RN K for injury. R152 was transferred to a loccal hospital for care and did not return to the facility. RN K no longer worked at the facility and voicemails requesting a return call to CENA J went unanswered.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain a Foley catheter drainage bag and tubing off the floor for 1 of 2 residents reviewed with Foley catheters (Resident #11), resulting in the potential for infection. Findings Include: Resident #11 (R11) On 08/26/20 at 10:03 AM R11 was observed in his room sitting up in his wheelchair cleanly clothed and dressed. R11's Foley catheter tubing was noted under his wheelchair draining cloudy yellow urine into the collection bag, with a reflected measurement of 25 cubic centimeters of urine. The drainage bag, was not covered with a dignity bag. The bottom of the Foley collection bag and tubing with an attached clip, used to empty the urine was observed not connected to the drainage bag, and was making direct contact with the carpeted floor. Later the same day at 03:59 PM Registered Nurse (RN R) was informed that R11's Foley catheter drainage bag tubing was observed without a dignity bag, making direct contact with the floor. RN R revealed she had witnessed the tubing touching the floor earlier and without a dignity bag, that R11's Foley catheter tubing/bag was changed and a dignity bag was added. The Electronic Medical Record (EMR) on 08/27/20 at 03:35 PM reflected R11 was admitted on [DATE], and had [DIAGNOSES REDACTED]. R11's quarterly Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date of 6/3/20 and his annual MDS with an ARD of 3/5/20 reflected R11 was cognitively intact, required extensive assistance of 2 persons for bed mobility and transfers, required extensive assistance of 1-2 persons for toilet use and hygiene, required extensive assistance of 1 person for dressing, and had a Foley catheter device. On 08/27/20 at 03:16 PM the Director of Nursing (DON B) was informed of the Foley tubing observation made on 8/26/20 and revealed the Foley bag and tubing should have been off the floor, below the insertion point with a dignity bag on, and that the drainage port should have been connected/clipped back into the device. R11's Urinary Tract Infection [MEDICAL CONDITION] care plan Last Reviewed/Revised: 08/26/2020 reflected: PROBLEM: Potential for urinary tract infection related to presence of suprapubic catheter and Hx UTI. Target Date: 09/08/2020 GOAL: Resident will not exhibit signs of urinary tract infection. If symptoms occur, they will be addressed and treated. Start Date: 08/26/2020 Start Date: 07/18/2018 APPROACH: Assess for UTI (burning, pain w/urination, urgency, frequency, bladder cramps/spasms, low back pain, flank pain, malaise, nausea, vomiting, pain/tenderness over the bladder, chills, fever, foul odor of urine, dark or concentrated urine, blood in urine, confusion) and report to MD Flowsheet: N/A Discipline: LPN, RN Frequency: N/A Start Date: 07/18/2018 APPROACH: Maintain catheter tubing below the level of the bladder. Flowsheet: N/A Discipline: Nursing Frequency: N/A Start Date: 07/18/2018 APPROACH: Observe and document intake and output and characteristics of urine. Flowsheet: N/A Discipline: Nursing Frequency: N/A Start Date: 07/18/2018 APPROACH: Use principles of infection control and universal/standard precautions when doing any treatments or catheter care. Flowsheet: N/A Discipline: Nursing Frequency: N/A The Drugs.com educational reference dated 2/3/20 reflected: Keep the drainage bag below the level of your waist. This helps stop urine from moving back up the tubing and into your bladder. Do not loop or kink the tubing. This can cause urine to back up and collect in your bladder. Do not let the drainage bag touch or lie on the floor.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to administer medication as ordered for 1 out of 6 residents reviewed for medication pass (Resident #45) resulting in an error rate of 5.71% due to 2 errors out of 35 attempts. Findings Include: On 8/28/20 at 08:00 AM, Registered Nurse (RN V) was observed during the medication pass for Resident #45 (R45). R45 was also ordered to receive 1 Multivitamin tablet orally every day. RN V dropped the medication on the floor and wasted it in the sharps container. RN V then revealed that was R45 last tablet in stock, no additional tablets were available to administer, and R45 did not offer R45 her multivitamin tablet. R45 was also ordered to receive [MEDICATION NAME] (diuretic) 40 milligrams (mg) 1 tablet twice a day (bid). RN V scored the tablet in half, gave 1/2 tablet

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F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) (20 mg) to R45 and wasted the remaining 20 mg in the sharps container. RN V was observed to have prepared the medication for R45, walked in R45's room and offered her the medication. Later the same day at 09:52 AM, RN V was interviewed that according to the physician's orders [REDACTED]. RN V revealed she was aware that R45 was to receive 20 mg, but was not aware she was to receive 40 mg. The facility's Medication Administration Policy revised January 2017 reflected: 5) The Medication Administration Record [REDACTED]. Prior to administration of any mediation, the medication and dosage schedule on the resident's MAR indicated [REDACTED]. When a medication order is changed and the current supply can continue to be used, the container should be flagged right away and the order change communicated to the provider pharmacy so that the next supply of the medication is labeled with the current directions.
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** Based on observation, interview and record review, the facility failed to A) Store medications and biologicals in the medication refrigerator according to the Centers for Disease Control (CDC) temperature guidelines, and B) Properly dispose of controlled and non-controlled medications, resulting in the likelihood in a decrease in efficacy of medication and a loss of potency so residents receiving the medication were not receiving the total action of the medication, the potential for drug diversion and adverse effects to the environment. Findings include: On 8/27/20 at 10:41 AM, in the presence of Licensed Practical Nurse (LPN) H, an observation of the contents of the medication refrigerator on the 100 unit was done. It was noted the following medications were stored in the refrigerator: three insulin pens (basaglar) and three vials of Humalog insulin for Resident #156 and one [MEDICATION NAME] Insulin pen and one Humalog insulin pen for Resident #155. In addition, there were 2 vials of [MEDICATION NAME] purified protein derivative (PPD) in the refrigerator. On 8/27/20 at 11:00 AM, Director of Nursing (DON) B reviewed the temperature logs for the 100 unit for July and August, 2020. DON B was asked whose responsibility it was to review the temperature logs from the medication refrigerators and he stated he was responsible. DON B was queried about the required temperature range for the storage of immunizations and biologicals. DON B stated the correct temperature range for medication storage was 35 to 40 degrees Fahrenheit. DON B was asked if you could freeze insulin. After thinking for awhile, DON B stated you should not freeze insulin. DON B was asked to contact the facility pharmacy, review the refrigerator temperatures with a pharmacist and request guidance about the storage of the medications in the unit 100 refrigerator. On 8/27/20, a record review of the medication temperature logs for the 100 unit for the months of July and August 2020 revealed the temperatures did not meet the centers for Disease Control accepted range for medication storage which is 36 to 46 degrees Fahrenheit. On 8/27/20, a record review of the July and August refrigerator temperature logs revealed the following information: In July, 2020, only one date (7/16/20) had a temperature documented within the required temperature range according to CDC guidelines (36 degrees Fahrenheit). The rest of the temperatures were between 30 and 32 degrees Fahrenheit with the exception of 7/27/20 where the temperature was documented as 34 degrees Fahrenheit. From 8/2/20 to 8/24/20, the documented temperatures were between 30 and 32 degrees Fahrenheit. No temperatures were documented for 8/1/20, 8/25/20 and 8/26/20. On 8/27/20, a record review of the form used to collect temperature data from the medication refrigerator revealed that the temperature log contained the name of the month, the unit name and a table with three columns. The first column contained the dates of the month, the second column had room to document the temperatures in the refrigerator and the third column had room to document the freezer temperatures. The form did not provide the CDC recommended temperature ranges for the storage of immunizations and biologicals or directions for actions to take if the temperatures are out of the recommended range. On 8/27/20 at 1:04 PM, a second interview with DON B occurred. DOB B was asked if the facility pharmacy was informed about the temperatures in the 100 unit medication refrigerator. DON B stated pharmacy indicated DON B was to discard the medications that were currently stored in the medication refrigerator. DON B stated the correct temperature range was between 35 degrees Fahrenheit and 40 degrees Fahrenheit. The Center for Disease Control (CDC) standards for storage of TB PPD ([MEDICATION NAME] Purified Protein Derivative), dated 4/3/2013, documented to keep the immunization in the refrigerator between 36 to 46 degrees, avoid temperature fluctuations and do not store in the refrigerator door. The manufacturer's instructions, dated 11/2013, noted the following statement for TB PPD: do not freeze. Insulin freezes almost as easily as water, and can be damaged by too much heat, so it's important to keep it protected from the elements. Once it's been opened, you can keep your insulin at room temperature for one month. Using insulin that's been frozen is dangerous, because if the protein has been damaged, it could mean the resident is not getting an adequate dose. The three major insulin makers - Eli Lilly, Novo [MEDICATION NAME], and Sanofi - tell us that refrigeration temperatures between 36 and 46F are maintained for insulin products during the manufacturing process and that remains the recommended range. They also warn strongly against putting insulin in the freezer, or directly adjacent to the refrigerator cooling element, as freezing renders insulin immediately ineffective. Resident #45 On 8/28/20 at 08:00 AM, Registered Nurse (RN V) was observed during the medication pass for Resident #45 (R45). R45 was ordered to receive the following medications at that time: -Tylenol Extra Strength 500 milligrams (mg) 1T po (orally) bid (twice a day) -[MEDICATION NAME] HBR/[MEDICATION NAME] (anti-depressant) 10 mg 1T po qd (daily) -Vitamin B-12 100 micrograms (mcg) 1T po qd -Multivitamin 1T po qd. RN V dropped the medication on the floor and wasted it in the sharps container. RN V then revealed that was R45's last tablet in stock, no additional tablets were available to administer, and R45 was not offered her multivitamin tablet -Eliquis (Anticoagulant) 5 mg give 2.5 mg po bid. RN V scored tablet in 1/2=2.5 mg, and wasted the remaining half in the sharps container -[MEDICATION NAME] (Diuretic) 40 mg po bid. RN V scored the tablet in 1/2=20 mg, and wasted the remaining half in the sharps container -[MEDICATION NAME] (Treats high blood pressure and heart failure) 10 mg 1T po qd -[MEDICATION NAME] (Muscle relaxant) 500 mg 1T po qid (four times a day) -[MEDICATION NAME] (Anticonvulsant and Nerve pain medication) 100 mg 1 capsule po tid (three times a day). The medication had a narcotic sheet to sign out doses, it was located in the double locked narcotic box, that was stored inside the medication cart. RN V was observed to have prepared the above medications for R45, walked into R45's room and offered R45 the above available medications, whereby R45 refused. After the exiting R45's room RN V disposed of the above medications in the sharps container, connected to her medication cart. Within minutes RN V revealed she needed a witness to waste the [MEDICATION NAME], that she had already placed in the sharps container. RN V called for RN C to come down the hall to her medication cart. RN V explained that she needed a witness to waste R45's [MEDICATION NAME]. RN C looked for the [MEDICATION NAME] to waste, however RN V explained that she had wasted it in the sharps container. RN C revealed that RN V should have gotten a witness prior to wasting the [MEDICATION NAME], and that medications were to be wasted in the drug buster located in the medication rooms. On 8/28/20 at 12:57 PM the Director of Nursing (DON B) was informed that medications including [MEDICATION NAME] were disposed in a sharps container, whereby DON B revealed that the medications should have been disposed of in a drug buster located in the medication rooms. The facility's Disposal of Medications and Medication-related supplies IE1: Controlled Substances Disposal policy revised January 2017 reflected: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility in accordance with federal and state laws and regulations. B. When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason, it is not placed back in the container. It is destroyed in the presence of two licensed facility personnel as permitted by regulations, and the disposal is documented on the accountability record/book on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose [MEDICATION NAME] and doses of controlled substances wasted for any reason. The facility's Disposal of Medication and Medication-Related Supplies policy dated January 2017 reflected: A. Unused and non-returnable medications should be removed from their storage area and secured in a designated area, until destroyed. B. Medications should not be flushed down the toilet or drain unless specifically instructed in the package insert to do so. C. Options to dispose of non-flushable prescription-drugs include: 1) The facility may be able to take advantage of a community take-back program or other program that collects drugs at a central location for proper disposal. 2) If a drug take-back or collection program in not available: a. Remove medications from their original containers. b. Mix drugs with an undesirable substance, such as cat litter or used coffee grounds. c. Put the mixture into a disposable container with lid, such as a 5-gallon bucket, or into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235538	A. BUILDING _____ B. WING _____	**09/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT HEALTH CAMPUS OF JACKSON	**703 ROBINSON RD JACKSON, MI 49203**

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

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F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) a sealable bag. Place in an opaque bag and dispose in the trash. d. Dispose of drug packaging in the trash making sure that no resident identifiers are on the labels and following pertinent regulations The State of Michigan Licensing And Regulatory Affairs Department online reference reflected: January 9, 2019 - In an effort to continue to combat the opioid epidemic in Michigan, the Dept. of Licensing and Regulatory Affairs (LARA), with the support of the Michigan Board of Pharmacy, has modified its Pharmacy Rules to categorize [MEDICATION NAME] as a Schedule 5 controlled substance. [MEDICATION NAME] - or [MEDICATION NAME] - is a medication commonly used to treat nerve pain and [MEDICAL CONDITION]. However, the drug can have potentially harmful effects when combined with other opioids. Michigan joins a growing number of states that have scheduled [MEDICATION NAME] as a controlled substance. Using a data-driven approach, we identified [MEDICATION NAME] as an emerging threat in our state and took necessary action to protect Michigan residents, said LARA Director (name of Director). The scheduling of [MEDICATION NAME] and improved training requirements for licensees outlined in these rule changes will continue to assist our efforts to curtail the opioid epidemic in Michigan while enhancing awareness about opioid addiction . The United States Drug Enforcement Administration (DEA) online reference reviewed on 9/1/20 reflected the following for a schedule 5 controlled substance: Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics.