STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235357	A. BUILDING _____ B. WING _____	03/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NSG & PHYSICAL REHAB CTR OF BELDING	414 E STATE ST BELDING, MI 48809

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 0553 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Allow resident to participate in the development and implementation of his or her person-centered plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 649 Based on interview and record review, the facility failed to attempt to involve a Resident's Durable Power of Attorney (DPOA) in an initial care conference meeting for one (Resident #9) of 9 reviewed for care planning, resulting in the potential for residents and/or responsible parties not being involved in the plan of care. Findings include: Review of face sheet and electronic medical record (EMR) for Resident #9 revealed he admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #9's Initial Minimum Data Set (MDS) Assessment completed on [DATE]20 revealed a Brief Interview for Mental Status (BI[CONDITION]) score of 3/15, indicating severe cognitive impairment. Resident #9 entered the facility with an activated DPOA due to incapacity. During an interview with Resident #9's DPOA, Family Member (FM) C on [DATE]20 at 12:13 PM, his involvement in Resident #9's plan of care was discussed. FM C stated that Resident #9 admitted to the facility on a Thursday and he visited with Resident #9 three times a day on Friday and Saturday. FM C stated other family members also were visiting on those days. FM C stated he had met with the social worker and physical therapist, but no one informed him about a meeting. FM C stated he found out later there had been a conference about Resident #9's care plan that he was not invited to. FM C stated he was upset that he was not included, and the facility did not try to include him. FM C stated he would have made himself available. FM C stated he provided DPOA paperwork to the facility on admission, so it was made crystal clear on admission that FM C was to make medical decisions for Resident #9. FM C stated he was not offered or provided a copy of the plan of care and only found out a meeting had occurred on [DATE]20. FM C stated he was made aware Resident #9 had attended that meeting, but said Resident #9 is in no way able to actively participate in any kind of decision making related to his care due to his advanced medical conditions. At that time, the family decided to take Resident #9 home. On 3/11/2020 at approximately 1:15 PM an interview was completed with the DON (Director of Nursing), SW (Social Worker) H and Unit Manager (UM) I. SW H and UM I stated they were present for Resident #9's initial care conference on 2/21/2020. SW H stated the dietician and Resident #9 were also present at the care conference. SW H stated the family of Resident #9 was present in the facility during the day the conference was held and they did drop the ball by not having them present for the initial care conference. SW H stated they could not coordinate the staff to be available when the family was there. SW H stated family is typically not there for initial care conferences but they try to have them involved. SW H admitted that it is difficult for family to be involved if they are not provided notice. UM I confirmed that FM C would probably have liked to be involved in the initial care conference. Review of facility provided policy Baseline Care Plan- Comprehensive Person-Centered Care Planning with a most recently revised date of 6/19 revealed: The facility will develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Initial care conference will be held within 72 hours of admission and quarterly thereafter. Further guidelines include: the facility shall gather information from.discussion with the resident and resident representative, if applicable.Once established, goals and interventions shall be documented in the designated format
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 649 Based on interview and record review, the facility failed to complete and provide 1 resident (Residents #9) of 9 reviewed for care planning, and their representatives with an understandably written summary of a baseline care plans, resulting in the potential for residents/resident representatives to be uninformed and/or misinformed of plans of care related to their individual care needs. Findings include: Review of face sheet and electronic medical record (EMR) for Resident #9 revealed he admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #9's Initial Minimum Data Set (MDS) Assessment completed on [DATE]20 revealed a Brief Interview for Mental Status (BI[CONDITION]) score of 3/15, indicating severe cognitive impairment. Resident #9 entered the facility with an activated DPOA due to incapacity. During an interview with Resident #9's DPOA, Family Member (FM) C on [DATE]20 at 12:13 PM, his involvement in Resident #9's plan of care was discussed. FM C stated that Resident #9 admitted to the facility on a Thursday and he visited with Resident #9 three times a day on Friday and Saturday. FM C stated other family members also were visiting on those days. FM C stated he had met with the social worker and physical therapist, but no one informed him about a meeting. FM C stated he found out later there had been a conference about Resident #9's care plan that he was not invited to. FM C stated he was upset that he was not included, and the facility did not try to include him. FM C stated he would have made himself available. FM C stated he provided DPOA paperwork to the facility on admission, so it was made crystal clear on admission that FM C was to make medical decisions for Resident #9. FM C stated he was not offered or provided a copy of the plan of care and only found out a meeting had occurred on [DATE]20. FM C stated he was made aware Resident #9 had attended that meeting, but said Resident #9 is in no way able to actively participate in any kind of decision making related to his care due to his advanced medical conditions. At that time, the family decided to take Resident #9 home. On 3/11/2020 at approximately 1:15 PM an interview was completed with the DON (Director of Nursing), SW (Social Worker) H and Unit Manager (UM) I. SW H and UM I stated they were present for Resident #9's initial care conference on 2/21/2020. SW H stated the dietician and Resident #9 were also present at the care conference. SW H stated the family of Resident #9 was present in the facility during the day the conference was held and they did drop the ball by not having them present for the initial care conference. SW H stated they could not coordinate the staff to be available when the family was there. SW H stated family is typically not there for initial care conferences but they try to have them involved. SW H admitted that it is difficult for family to be involved if they are not provided notice. UM I confirmed that FM C would probably have liked to be involved in the initial care conference. The DON, SW H and UM I were informed that upon review of the EMR, no copy of the baseline care plan could be located. SW H stated the progress note would summarize the baseline care plan. The care plan progress note was reviewed with them and they agreed that the note did not provide significant information. The DON stated that the care plan is started on admission and continues to be modified. There was no separate document to indicate what information was on the baseline care plan and what was discussed at the initial care conference. The baseline care plan information would have been available on the EMR dashboard if the resident was still admitted and this is what would be printed and provided to the family or resident if requested. Review of the Care Conference Summary from 2/21/2020 at 1:06 PM in the progress notes revealed: Summary of Discussion: Introduction of staff. Medication Review, Resident/RP Understanding/Concerns: No questions. Advanced Directives Reviewed/Revisions: DNR.

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

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.

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Goals Reviewed, Any changes to goals, Resident/RP Input: No goal. Wants to return home. Discharge Potential: Good. Baseline Care Plan Summary must be provided, doc. Who received. Care plan offered: declined of given?: Declined. Resident/Family attendance (indicate if invited): (Resident #9) Staff attending: (SW H, Registered Dietician M, UM I) Review of facility provided policy Baseline Care Plan- Comprehensive Person-Centered Care Planning with a most recently revised date of 6/19 revealed: The facility will develop and implement a baseline care plan for each resident that includes instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. Initial care conference will be held within 72 hours of admission and quarterly thereafter. Further guidelines include: the facility shall gather information from.discussion with the resident and resident representative, if applicable.Once established, goals and interventions shall be documented in the designated format and A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.