STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION		(X3) DATE SURVEY COMPLETED	
		384200	B. WING			3/30/2	023	
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE	
MISSION POI	NT HEALTH CAI	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
F0000 SS=	surveyed for an A Intakes: MI00135	ENTS alth Campus of Jackson was bbreviated survey on 3/30/2023. 247, MI00135044, 00134575, MI00131460.	F0000					
F0585 SS= D	§483.10(j)(1) The voice grievances agency or entity without discrimin fear of discrimin grievances inclu and treatment well as that whice the behavior of s and other conce facility stay. §48 the right to and the efforts by the face the resident may this paragraph. § must make infor grievance or cor resident. §483.1 establish a griev prompt resolution the residents' rig paragraph. Upon give a copy of the resident. The gri (i) Notifying reside postings in prom the facility of the (meaning spoke file grievances a	3.10(j) Grievances. e resident has the right to s to the facility or other that hears grievances hation or reprisal and without de those with respect to care hich has been furnished as the has not been furnished, staff and of other residents, rns regarding their LTC 3.10(j)(2) The resident has he facility must make prompt sility to resolve grievances v have, in accordance with §483.10(j)(3) The facility mation on how to file a nplaint available to the 0(j)(4) The facility must ance policy to ensure the n of all grievances regarding hts contained in this n request, the provider must e grievance policy to the evance policy must include: dent individually or through innent locations throughout right to file grievances orally n) or in writing; the right to nonymously; the contact e grievance official with	F0585	Facility assista April si reviewe residen all conce Elemer The Ad comple Elemer The Ad corpora family of The Ad manag grievan The ad activitie proced forms of Facility	nt 1 no longer resides at the completed grievance/resident forms for resident #2 or resident council minutes and ed for concerns and verified that assistant forms were cor- cerns on 4/28/23. In the fact that reside at the facility or be affected by the deficit for solution assistant forms of ted by 5/4/2023. In the fact of the fact of the fact of the ters on the resident and far the compliance officer on re- grievance policy on 4/21/22 iministrator re-educated the ers on the resident and far the policy. ministrator re-educated the seand recreation aides on ure for completed concern on 4/24/23. In the fact of the color of pape that assistant forms to bright changed the color of pape the council resident assistant	dent a 4/28/2023. were d that npleted for by have the t practice. An was ed by the esident and 3. e department mily e director of the /grievance er for the green. er for	5/5/2023	
LABORATORY	DIRECTOR'S OR P	ROVIDER/SUPPLIER REPRESENT	ATIVE'S SIGNA	TURE	TITLE	(X6) DA	TE	

Electronically Signed

04/28/2023

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.

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 384200		À. BUILDII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 3/30/2023		
IAME OF PROVIDER OR S					STREET ADDRESS, CITY, STATE 703 ROBINSON RD JACKSON, MI 49203		, ZIP CODE	
PRÉFIX (EACH D	EFICIEI EGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD E :FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
her name email) an reasonat completin right to of his or her informatii whom gri pertinent Organiza State Lor or protec Identifyin responsil process, through t necessar maintaini informatii example, grievand written gr and coor agencies allegatior immediat violations alleged v Consister reporting neglect, a source, a property, behalf of the provi (v) Ensur decisions received, residents	, busin d busin d busin le expo g the r otain a g grieva of fine state a tion, St g-Terr tion and g a Gri oble for of their y inves ing the or asso the ide es subr ievance dinating as neo as fill the pro- der; any the pro- der; any the pro- der;	ce can be filed, that is, his or less address (mailing and less phone number; a lected time frame for eview of the grievance; the written decision regarding nnce; and the contact dependent entities with as may be filed, that is, the agency, Quality Improvement ate Survey Agency and n Care Ombudsman program d advocacy system; (ii) evance Official who is overseeing the grievances conclusions; leading any tigations by the facility; confidentiality of all ociated with grievances, for entity of the resident for those nitted anonymously, issuing e decisions to the resident; g with state and federal resident right while the tis being investigated; (iv) §483.12(c)(1), immediately ged violations involving including injuries of unknown nisappropriation of resident to ne furnishing services on ovider, to the administrator of d as required by State law; t all written grievance e the date the grievance was many statement of the s or conclusions regarding		discuss Any de membe educate prior to Elemen The ad weekly timely of The ad monthly comple concern months Audit re monthly attends	ministrator/designee will co audit of resident assistant completion for three months ministrator/designee will co y audit on resident council i tion of resident assistant fo ns voiced during resident co soults will be reviewed at th y QAPI meeting that the Ad	eation team 3 will be next shift omplete a forms for s. omplete a minutes for orms for ouncil for 3 e facilities Iministrator		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:			STRUCTION	(X3) DATE SURVEY COMPLETED	
		384200	B. WING			3/30/2	2023
NAME OF PRC	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CC	DE
MISSION POINT HEALTH CAMPUS OF JACKSON					703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE (FERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
	 whether the griev confirmed, any confirmed, and the alleged rights is confirmed outside entity has state Survey Ag. Organization, or agency confirms residents' rights is confirmed, and confirmed of the aperiod of no lease issuance of the generation of the generating the generating the generating the gener	ad (vii) Maintaining evidence he result of all grievances for ss than 3 years from the grievance decision. IENT is not met as ins to intake: MI00134575, ion, interview and record failed to ensure that grievances and resolved for two Residents members of the resident council ement facility grievance policy, gs of anger, frustration and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		384200	B. WING			3/30/2	2023
NAME OF PROVIDE	R OR SUPPLIE	R			STREET ADDRESS, CITY, STA	TE, ZIP CO	DE
MISSION POINT H	HEALTH CAM	PUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
PRÉFIX (E	EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	//IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
hea diai MI sco dai req mo hyg Ret Mii 202 con of s Du NH CO NH NH con add wit log Ret Ret Ret Nii 202 con of s	art rythem, heart betes with use of DS reflected R1 re of 14 which i ly decisions was uired one persor- biblity, transfers, giene, toileting, a view of the com chigan, dated 2/ dication admini- sod sugars and st view of the mon nutes, dated Oct 23, reflected resi- ncerns on 12/30/ six months reque- ring an interview IA "A" reported neern forms or e onthly resident co- ncerns October 2 d would expect t th use of comple aged on grievance view of the facil port", dated 2/4/ received physic 53 occasions. The ministered media 0 (treatment of a urs late accordin iorted reflected I st acting insulin). lered prior to ead	plaint submitted to the State of 13/23, reflected concerns with stration and monitoring of affing concerns. thly Resident Council Meeting ober 2022 through March dents reported staffing 22, 1/27/23 and 3/27/23 (three ested). w on 3/30/23 at 10:20 a.m., the facility did not have any vidence of follow up for puncil meetings reported 2023 through February 2023 o see evidence of follow up ted grievance forms and e log. ity "Medication Admin Audit 23 through 2/6/23, reflected ian ordered medications late he reported reflected R1 was cation that included Cardizem trial fibrillation) over eight gover eight hours late that was					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI PLAN OF CORRECTION IDENTIFICATION NUMBER:		A (X2) MULTII A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED	
		384200	B. WING _			3/30/2	023
	VIDER OR SUPPLIE				STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	reflected no evider medications admir medications and ir other late physicia During an intervie Director of Nursin expect if residents medication timing if not given as ord documentation cor reported would exj hour prior or one F time of administra During an observa at 3:45 p.m., R1 vw with medication ti complaints made t reported continued R1 reported continued R1 reported usuall staff. During an intervie Director of Nursin hired as Assistant month ago and wa two weeks. DON ' one nurse on 200 F medication and tre hours because too frequency of treatt mostly an issue wi reported most 25 r assist.	nce of physician notified of late histration including cardiac sulin for blood sugar or several ns ordered medications. w on 3/30/23 at 2:50 p.m. g (DON) "B" reported would reported concerns with an infestation should occur and ered physician notified and mpleted in EMR. DON "B" pect medication to be given one hour after physician ordered tion. tion and interview on 3/30/23 erified had reported concerns ming with the facility prior to o the State of Michigan and l issues with late medications. y an issue with the agency w on 3/30/23 at 1:41 p.m., g (DON) "B" reported was Director of Nursing about one s now interim DON for past "B" reported had identified that hall is impossible to compete all eatment orders timely in two many medications and nents and reported usually th agency staff. DON "B" esidents require two-person			DEFICIENCY)		
	at about 3:30 p.m., locate R1 Grievant to concerns about reported the form	w and record review on 3/30/23 , NHA "A" reported was able to ce Form, dated 2/6/23, related medication timing. NHA "A" had not been completed and completed within seven days					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ISTRUCTION		(X3) DATE SURVEY COMPLETED	
		384200	B. WING				2023	
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DE	
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	and reported prior grievance.	DON was assigned to						
	Resident #2(R2)							
	(MDS) dated 3/8/2 old female admitte with diagnoses tha blood pressure), cl disease, cancer, in and depression. TI BIM (assessment ti indicated her abili cognitively intact, physical assist wit locomotion on uni	e Sheet and Minimum Data Set 23, reflected R2 was a 70-year- ed to the facility on 10/10/20, tt included hypertension (high hronic obstructive pulmonary mune compromised, anxiety, ne MDS reflected R2 had a tool) score of 14 which ty to make daily decisions was and she required one-person h bed mobility, transfers, t, dressing, hygiene, toileting, IDS reflected no evidence of						
	at 12:30 pm, R2 w wheelchair, appear without difficulty. staff transport R2 wheelchair just pri with agency staff medications to her about 3 weeks prio was completed and was given to her a without their know nurse the morning medication and im reported had anott concerns with late staffed. Review of the Res 1/9/23, reflected R short staffing and	tion and interview on 3/30/23 ras in room sitting in red able to answer questions This surveyor had observed from Dining room to room via ior. R2 reported did have issue who administered wrong and other residents on the hall or. R2 reported investigation d determined to be Benadryl nd other residents on the hall vledge. R2 reported told her after R2 received unknown vestigation was done. R2 her time she reported had medications related to short ident Concern Form, dated t2 reported concerns related to late medications ordered in nistered after 3:00 p.m. The						

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		384200	B. WING _			3/30/2	2023	
NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATI	, ZIP CO	DE	
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CI FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
	and plan to hire ad provided to staff tr act more professio document to did ne to see if plan was of Review of R2 Inci 3/4/23 at 10:11 a.n approached this nu med pass and aske florescent pink pill last night were. Af MAR and verifyin out were bright pir medications. The c that I found contai our "complete alle pills to the residen were in fact the pill the night before. N vitals are WNL an pain at this time ar notified of alleged Review of R2's Ph current (3/30/23), for Complete Aller During a telephone p.m., Licensed Pra reported R2 report that she had receiv the night prior that "K" reported R2 cc morning. LPN "K" identify pink tabs s when visually shou informed NHA "A "L". LPN "K" repor	dent/Accident report, dated n., reflected, "Resident trse this morning during am d me if I knew what the "two ls" that she got with her meds ter going through the residents g that none of the meds signed ak I looked at our stock only bottle of OTC medications ning florescent pink pills were rgy relief". I presented these t and she verified that they ls she had received in her meds fursing assessment compleited d patient has no complaints of th is currently stable. DON						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 384200		À. ÉUILDI	NG	ČOMF	X3) DATE SURVEY COMPLETED 5/30/2023	
	INT HEALTH CAI	ER MPUS OF JACKSON	STREET ADDRESS, CITY, ST 703 ROBINSON RD JACKSON, MI 49203			TATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECTION (EACH RECTIVE ACTION SHOULD BE CROSS- :FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0656 SS= D	Director of Nursin hired as Assistant month ago and wi- two weeks. DON to her 3/4/23 that concerns from nigh had complained tit tired on 3/4/23. D was completed an night of 3/3/23 wi reported facility h to return to the fa "B" reported found in had not been prio medication carts. identified that one to compete all me timely in two hou medications and f reported usually r staff. DON "B" re two-person assist. Develop/Implem \$483.21(b) Corr \$483.21(b) Corr \$483.21(b)(1) T implement a cor care plan for ea the resident smedic psychosocial ne comprehensive following - (i) Th	ew on 3/30/23 at 1:41 p.m., ng (DON) "B" reported was Director of Nursing about one as now interim DON for past "B" reported LPN "K" reported R2 reported medication th prior. DON "B" reported R2 D LPN "K" about being extra ON "B" reported investigation d determined was agency nurse no was questioned. DON "B" ad not allowed that agency staff cility after the incident. DON esidents had an order for y on hand for allergy and medication room opened and r and verified not kept on DON "B" reported had e nurse on 200 hall is impossible dication and treatment orders rs because too many requency of treatments and nostly an issue with agency ported most 25 residents require	F0656	Elemer Reside bowel s	nt #3 was re-assessed on the ability to ate in his bowel program and person care plan was developed on 4/28/2023 It #2 Ints that reside at the facility and use a stimulator have the ability to be affected beficit practice. Residents □ care plans viewed to ensure person center care 2023.		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER: 384200		À. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 3/30/2023	
	VIDER OR SUPPLIE	ER MPUS OF JACKSON			STREET ADDRESS, CITY, S 703 ROBINSON RD JACKSON, MI 49203	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	psychosocial we §483.24, §483.24 services that wo under §483.24, § not provided due rights under §48 refuse treatment Any specialized rehabilitative ser provide as a resi- recommendation the findings of th- its rationale in th- (iv)In consultatio- resident's represi- resident's represi- resident's goals outcomes. (B) Ti- potential for futu document wheth return to the com- any referrals to I other appropriative (C) Discharge pl care plan, as app the requirements this section. §48 provided or arrai- outlined by the c must- (iii) Be cul trauma-informed This REQUIREN evidenced by: This citation perta MI00135247. Based on observat review the facility two residents (Res	ns. If a facility disagrees with the PASARR, it must indicate the resident's medical record. In with the resident and the sentative(s)- (A) The for admission and desired the resident's preference and re discharge. Facilities must there the resident's desire to munity was assessed and ocal contact agencies and/or e entities, for this purpose. ans in the comprehensive propriate, in accordance with s set forth in paragraph (c) of 3.21(b)(3) The services inged by the facility, as comprehensive care plan, turally-competent and		the regi compre- The Dir the inte plannin QAPI m discuss Change develop will be of meeting Any nui educate prior to Elemen Directo random accurac weeks, 4 week Audit re monthly Adminis The Ad	se not educated by 5/5/20 ad at the beginning of their working. t #4 r of Nursing/Designee will o weekly audit 10% of the re biweekly for 4 weeks and b	the n 4/27/2023. re-educated ses on care 023 to the care plan linical 23 will be next shift complete a esidents for lans for 4 monthly for that the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		384200	B. WING _			3/30/2	023
NAME OF PROV	VIDER OR SUPPLIE	ĒR		S	STREET ADDRESS, CITY, STATE,	ZIP CO	DE
MISSION POINT HEALTH CAMPUS OF JACKSON					703 ROBINSON RD IACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	CORRE	DER'S PLAN OF CORRECTION (E/ ECTIVE ACTION SHOULD BE CRO ERENCED TO THE APPROPRIATI DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	resulting in the po- unment.	tential for care needs to go					
	Findings Include:						
	Per the facility face sheet Resident #3 (R3) was admitted to the facility on 3/4/2022. Diagnosis included constipation.						
	Review of Physician's orders dated 6/15/2022, revealed R3 had an order in place for, "Daily Bowel Program using Digital Rectal stimulation (insertion of finger into rectum). After insertion of the daily Bisacodyl suppository (inserted into the rectum in order to cause a bowel movement), wait 10-15 min then do digital simulation of rectal wall (touch/tap around the wall of the rectum for 20-30 seconds) to help stimulate evacuation of the bowel						
		very 10-15 min up to 4 times. bowel care program."					
	Review of another Physician's order dated 5/13/2022, revealed an order for R3 to receive, "Bisacodyl Suppository 10 MG (milligrams) Insert 10 mg rectally in the morning for constipation hold if loose stools."						
	record (MAR) for February, and Man mentioned physici on R3's MARs in signed by initial th	R3's medication administration the months of January, rch 2023 revealed that the two ian's orders were documented which licsensed nursing staff nat R3's daily bowel program pository was provided and					
	"Focus" of, "I (R3 daily living) Self (re plan in place revealed a) have an ADL (activities of Care and mobility Performance to) QUADRIPLEGIA					

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	6 (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	384200	B. WING _		3/30/2023
NAME OF PROVIDER OR SUP	LIER		STREET ADDRESS, CITY, S	STATE, ZIP CODE
MISSION POINT HEALTH C	AMPUS OF JACKSON		703 ROBINSON RD JACKSON, MI 49203	
PRÉFIX (EACH DEFIC	STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY LATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS- COMPLÉTION
SECONDARY	TO cervical spinal cord			
injury." dated The intervention Program using Digital Rectal daily Bisacody do digital stime around the way seconds) to he bowel contents times. Encoura- independently, 12/19/2022. TI "Position" resp Review of R3' of care with a a self-supposit stimulator.", d 12/19/2022. TI of, "I (R3) hav suppository in rectal stimulat order to self ac perform self re myself per my revised on 12/ intervention, u intervention w Nurse (RN) or An interventio suppository in to insert not (s and under "Poo assigned to an plan revealed a encourage me	8/4/2022 and revised on 10/5/2022. ons in place included, "Daily Bowel Suppository insertion device and stimulation. After insertion of the 1 suppository, wait 10-15 min then ilation of rectal wall (touch/tap 1 of the rectum for 20-30 p stimulate evacuation of the . Repeat every 10-15 min up to 4 ge me (R3) to do this " dated 6/15/2022 and revised on the intervention revealed the onsible was an RN/LPN. a care plans revealed an active plan Focus" of, "Bowel Program using bry inserter, and self-rectal ted 11/2/2022 and revised on the care plan included interventions e a personal adaptive rectal tertion device and an adaptive or device (device for R3 to use in minister the suppository and ctal stimulation) that I will use on request.", dated 11/2/2022 and			

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION	(X3) DATE SURVEY COMPLETED	
		384200	B. WING _			3/30/2	023
NAME OF PROVI	DER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MISSION POIN	T HEALTH CAM	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
		12/19/2022, and under vention was assigned to an n.					
I I I I I I I I I I I I I I I I I I I	12:56 PM, R3 state his bowel program suppository every in neer the supposit he did have the devo lowel program and himself, but said the himself because he and also did not no further stated that I stimulation every r Certified Nurse Ai who administered I icensed nurses did R3 continued to state eeded the rectal si CNA "E" was the operformed this for also stated that ever working on her day acility in his room him his suppository in an interview on "E" said she admin ligital rectal stimu here was no set tif suppository or perf CNA "E" said the operformed that for attimulation he was further stated that the working on her day acility in his room him his suppository at stimulation he was compository at the stated that the were stored in R3's cabinet. CNA "E"	ate that he was constipated and timulation every morning, and only staff member who him when he would ask. R3 in when CNA "E" was not ys off, she would be at the h, and even the administered					

STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	A (X2) MULTIF A. BUILDING		STRUCTION		ATE SURVEY PLETED
		384200	B. WING _			3/30/2	2023
					STREET ADDRESS, CITY,	STATE, ZIP CC	DDE
MISSION POI	NI HEALIH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	stated that R3' bow to him a supposito nurses administered	3/29/2023 at 3:05 PM, RN "F" vel program was to administer ry every morning, RN "F" said ed R3 his suppository.					
	"C" stated, upon a administered R3's bowel stimulation, his suppository an stimulation. At 8:0 with LPN "C", CN the floor with appr suppositories on tt packaging. LPN "C" "E" that she could Bisacodyl supposi in which CNA "E' asked R3 if she co suppository howev he was comfortabl no he was not, and	3/30/2023 at 7:50 AM, LPN sking the question of who suppository and performed his , that nursing administered R3 d performed the bowel 05 AM upon entering R3's room IA "E" was observed sitting on roximately six Bisacodyl ne floor next to her still in the C" made a comment to CNA see that CNA "E" had tories next to her on the floor, ' replied "yes". LPN "C" then uld administer him his ver, CNA "E" then asked R3 if le with that, in which he stated I that CNA "E" always Bisacodyl suppository to him.					
	In an interview on stated she did not i administering R3 J digital rectal stimu "E". RN "I" furthe suppositories were was in the locked i locked and stores i has a key to open) that the medication RN "I" additionall CNA "E" administ suppository. In an interview on "D", who was also	3/30/2023 at 8:24 AM, RN "I" know who had been his Bisacodyl suppository, and ilation to him other than CNA or stated that Bisacodyl to be in the refrigerator that medication room (room that is medications that only the nurse because the facility policy was					

STATEMENT OF AND PLAN OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384200	À. BUILDI	TIPLE CONSTRUCTION NG	COMP	
	/IDER OR SUPPLIE	ER MPUS OF JACKSON		STREET ADDRESS, CIT 703 ROBINSON RD JACKSON, MI 49203	Y, STATE, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR CORRECTIVE ACTION SHOU REFERENCED TO THE AP DEFICIENCY)	LD BE CROSS-	(X5) COMPLETIOI DATE
F0725 SS= D	was a CNA to adr LPN "D" said she administering R3 stated that medica resident's room. L suppositories were medication room In an interview or Director of Nursir was not to admini and said not even she was not aware administering R3 suppositories were that both were ina Review of the fac titled, "MEDICA" GENERAL GUII GENERAL GUII GENERAL GUII GENERAL GUI GENERAL GUI GENERAL GUIS ipersonnel.", and " Medications are a nursing or medica Sufficient Nursin Staff. The facility staff with the apy skills sets to pro services to assu or maintain the f mental, and psy resident, as dete assessments an and considering diagnoses of the in accordance w	ility's policy and procedure FION PREPARATION- DELINES" dated June 2019, PROCEDURES", "A. dications are prepared only by medical, or pharmacy B. Administration 1) dministered only by licensed	F0725	Element #1 Resident #1no longer resides Resident #2 was interviewed f times for bathroom use and if received any allergy medication Element #2 Residents that reside at the fa ability to be affected by the de audit of medication administra reviewed by 5/5/2023. Residents were audited for tim light response time by 5/5/202	or call light she had in on 4/28/2023. cility have the ficit practice. An tion times was heliness of call	5/5/2023

STATEMENT OF DEFICI AND PLAN OF CORREC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384200	À. ÉUILDI	NG	STRUCTION		ATE SURVEY 'LETED 2023
NAME OF PROVIDER O					STREET ADDRESS, CITY, S 703 ROBINSON RD JACKSON, MI 49203	STATE, ZIP CC	DE
PRÉFIX (EACH	I DEFICIEI REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	LIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE
person nursing with re waived license person aides. under p facility serve a This R eviden This Ci MI0013 MI0013 Based o review nursing resultin resided their hip psychoo needs, a Finding Review Census 3/29/23 which 4 for bath staff for two staff of one o assistan CMS-6 depend	nel on a 2 g care to a sident cau lunder pa d nurses; nel, inclu §483.35(a paragraph must des as a charg EQUIREN ced by: tation Pert \$4639, MI(81460 on observa the facility staff for 2 g in the pa g in the pa at the faci ghest pract social well and medica as include: to of the fac and Condi revealed of the reasing, ff for trans or two staff	n of the following types of 24-hour basis to provide all residents in accordance re plans: (i) Except when aragraph (e) of this section, , and (ii) Other nursing ding but not limited to nurse a)(2) Except when waived n (e) of this section, the ignate a licensed nurse to ge nurse on each tour of duty. MENT is not met as ains To Intakes: MI00134247, 00135044, MI00134575, toon, interview, and record failed to ensure sufficient of 5 resident (R1 and R2) tential for all 48 residents who lity to not attain or maintain icable physical, mental, and -being related to unmet care ation errors. ility's CMS-672 Resident titons of Residents dated the facility's census was 48, of a assistance of one or two 38 required assistance of one or for toilet use, and 1 required or two staff for eating. The realed 6 residents were f for bathing, 3 were dependent ng, 6 were depending on staff		the reg medica respons The dir the nur times. The dir all staff The fac nurses QAPI n discusse Any sta educate prior to Elemen Directo random respons weeks, monthly attends The Ad	ector of nursing was re-ed ional director of clinical reg tion administration times a setimes on 4/27/2023. ector of nursing/designee i ses on medication adminis ector of nursing/designee i on answering of call lights ility updated assignments and certified nursing assis neeting was held on 4/24/2 root cause analysis. If not educated by 5/5/202 ed at the beginning of their working. At #4 r of nursing/designee will of tion administration times for y for 4 weeks and then mo r of nursing/designee will of a audit for timeliness of call se times on 20% of the res biweekly for 4 weeks and /. sults will be reviewed at th y QAPI meeting that the Ad	parding ind call light re-educated stration re-educated a. for the tants. 2023 to 23 will be r next shift complete a esident or 4 weeks, onthly. complete a light idents for 4 then he facilities dministrator	

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:			ISTRUCTION		ATE SURVEY LETED
		384200	B. WING _			3/30/2	2023
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DE
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE FERENCED TO THE APPROP DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
		were dependent on staff for ere dependent on staff for					
	Findings include:						
	Resident #1(R1)						
	(MDS) dated 1/7/2 old female admitte with diagnoses tha blood pressure), cl disease, heart failu heart rythem, hear diabetes with use c MDS reflected R1 score of 14 which daily decisions wa required one person	e Sheet and Minimum Data Set 23, reflected R1 was a 75 year 2d to the facility on 10/30/17, at included hypertension (high hronic obstructive pulmonary ure, atrial fibrilation(irregular t disease, bipolar disorder, of insulin, and depression. The had a BIM (assessment tool) indicated her ability to make is cognitively intact, and she on physical assist with bed , locomotion on unit, dressing, and bathing.					
	Michigan, dated 2/	nplaint submitted to the State of /13/23, reflected concerns with istration and monitoring of staffing concerns.					
	Minutes, dated Oc 2023, reflected res	nthly Resident Council Meeting tober 2022 through March sidents reported staffing /22, 1/27/23 and 3/27/23(three nested).					
	NHA "A" reported concern forms or e monthly resident c	w on 3/30/23 at 10:20 a.m., I the facility did not have any evidence of follow up for council meetings reported 2023 through February 2023.					
		lity "Medication Admin Audit /23 through 2/6/23, reflected					

STATEMENT OF AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING	PLE CON G	ISTRUCTION		ATE SURVEY LETED
		384200	B. WING _			3/30/2	2023
NAME OF PROVI	DER OR SUPPLIE	R			STREET ADDRESS, CITY, STATI	E, ZIP CO	DE
MISSION POIN	T HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CI FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
I I I I I I I I I I I I I I I I I I I	on 53 occasions. T administered medi CD (treatment of a hours late accordin reported reflected 1 (fast acting insulin ordered prior to ea Review of R1 EMI reflected no evider medications admin medications and in other late physician During an intervier Director of Nursin, expect if residents medication timing if not given as orded documentation cor reported would exp hour prior or one h time of administrat During an observa at 3:45 p.m., R1 ve with medication tin complaints made to reported usually staff. Resident #2(R2) Review of the Facc (MDS) dated 3/8/2 old female admitte with diagnoses tha blood pressure), cf disease, cancer, im	R, dated 2/1/23 through 2/6/23, ice of physician notified of late distration including cardiac isulin for blood sugar or several ns ordered medications. w on 3/30/23 at 2:50 p.m. g (DON) "B" reported would reported concerns with an infestation should occur and ered physician notified and npleted in EMR. DON "B" pect medication to be given one iour after physician ordered					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING		ISTRUCTION		ATE SURVEY LETED
		384200		B. WING _			3/30/2	023
		_						
						STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MISSION POI		IPUS OF JACKSON				703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	Ρ	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	indicated her abilit cognitively intact, physical assist wit locomotion on uni and bathing. R2 M behaviors. During an observa at 12:30 pm, R2 w wheelchair, appeat without difficulty. staff transport R2 wheelchair just pri with staffing with call light response (R2 room furthest did miss dinner on answered call ligh and reported did n during covid had t During a confiden 3/30/23 at 1:15 p.r reported 200 hall a 30 residents to per treatments for with very challenging to familiar with resid reported was unsu possibly complete timely without bei Confidential Staff 45 minutes alone f	tool) score of 14 which ty to make daily decisions was and she required one-person h bed mobility, transfers, t, dressing, hygiene, toileting, IDS reflected no evidence of tion and interview on 3/30/23 as in room sitting in red able to answer questions This surveyor had observed from Dining room to room via or. R2 reported had concern waiting up to 45 minutes for to use bathroom or go to meal. distance from DR). R2 reported e time because staff never to rassisted her to dining room ot like to eat in room because o every day. tial telephone interview on n., Confidential Staff "M" touity is high and includes 25 to form medication pass and in 2 hour window and was o complete even if you are ents. Confidential Staff "M" re how agency staff could medication pass and treatments ng familiar with routine. "M" reported R1 can take up to or medication pass and e of complex care required with sidents to see within same 2						
	During an intervie Director of Nursin hired as Assistant	w on 3/30/23 at 1:41 p.m., g (DON) "B" reported was Director of Nursing about one s now interim DON for past						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384200	À. BUILDI	TIPLE CONSTRUCTION NG	_ COMP	ATE SURVEY LETED 2023
	INT HEALTH CAN	ER BR MPUS OF JACKSON		STREET ADDRESS, CITY 703 ROBINSON RD JACKSON, MI 49203	, STATE, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOUL REFERENCED TO THE APPI DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE
50760	one nurse on 200 medication and tra- hours because too frequency of treat mostly an issue w reported most 25 m assist.	"B" reported had identified that hall is impossible to compete all eatment orders timely in two many medications and ments and reported usually ith agency staff. DON "B" residents require two-person	50760	Element #1		5/5/0000
F0760 SS= D	The facility must (2) Residents ar medication error This REQUIREN evidenced by:	ree of Significant Med Errors ensure that its- §483.45(f) e free of any significant 's. //ENT is not met as ains to Intake Numbers	F0760	Resident #1 □s no longer reside facility. Resident 2 was interviewed on determine if she had received a medication since the incident of Element #2 Residents that reside at the fac ability to be affected by the defi	4/28/2023 to Illergy n 3/4/23. ility have the	5/5/2023
	review, the facility medications were physician's orders and Resident #2) of resulting in missee residents voicing of medications, docu concerns, multiple	tion, interview and record y failed to ensure that prescribed given on time and per for two residents (Resident #1 from a sample of 5 residents, d doses of medications, current concerns of the late or missing immented in Resident Council e complaints to State Agency, for preventable decline.		audit of medication administrati medications were reviewed by set Element #3 The Director of nursing was re- the regional director of clinical r medication administration times do when there is a medication of 4/27/2023. The director of nursing/designe the nurses on medication admin	on times and 5/5/2023. educated by egarding s and what to error on e re-educated	
	(MDS) dated 1/7/2 old female admitted with diagnoses that blood pressure), c disease, heart failed	ee Sheet and Minimum Data Set 23, reflected R1 was a 75 year ed to the facility on 10/30/17, at included hypertension (high hronic obstructive pulmonary ure, atrial fibrilation(irregular		and what to do if there is a med The facility updated assignmen nurses and certified nursing ass QAPI meeting was held on 4/24 discuss root cause analysis. Any staff not educated by 5/5/2 educated at the beginning of the prior to working. Element #4	lication error. ts for the sistants. 1/2023 to 023 will be eir next shift	
	with diagnoses the blood pressure), c disease, heart fail	at included hypertension (high hronic obstructive pulmonary		prior to working.	ll complete a	

384200 B. WING	STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:			ISTRUCTION		ATE SURVEY LETED
MISSION POINT HEALTH CAMPUS OF JACKSON 703 ROBINSON RD JACKSON, MI 49203			384200	B. WING _			_ 3/30/2	2023
MISSION POINT HEALTH CAMPUS OF JACKSON 703 ROBINSON RD JACKSON, MI 49203								
JACKSON, MI 49203	NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
(X4) ID SLIMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (FACH (X5)	MISSION POI	NT HEALTH CAN	IPUS OF JACKSON					
		(EACH DEFICIEN FULL REGULAT	ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING		COR	RECTIVE ACTION SHOULD E FERENCED TO THE APPRC	BE CROSS-	(X5) COMPLETION DATE
diabetes with use of insulin, and depression. The MDS reflected R1 had a BIM (assessment tool) score of 14 which indicated her ability to make daily decisions was cognitively intact, and she required one person physical assist with bed mobility. transfers, locomotion on unit, dressing, hygiene, toileting, and bathing. medication administration times for 4 weeks, Audit results will be reviewed at the facilities monthy QAP1 meeting that the Administrator attends. Review of the complaint submitted to the State of Michigan, dated 21/323, reflected concerns with medication administration and monitoring of blood sugars. The Administrator is responsible for attaining and sustaining compliance Review of the Grievance Log, dated 1/1/23 through 32&023, reflected R1 had reported concerns with medication timeliness on 2/6/23. Requested Nursing Home Administrator (NHA) "A' for R1's Grievance Stard 21/23 at 92/0a.m. Review of email from NHA "A", dated 3/30/23 at 9:56 a.m., reflected 12/23.27 reflected to medication concerns. Review of the monthly Resident Council Meeting Minutes, dated October 20/23 through March 20/23, reflected residents reported concerns about timeliness of medication administration on 12/2022, 1/27/23 and 32/27/21 three of six months requested). During an interview on 3/30/23 at 10:20 a.m., NHA "A" reported the facility di don thave any concern forms or evidence of follow up for monthly resident council meetings reported concerns of the galeent concerns for late medications. Berview of the facility "Medication Admin Audit		MDS reflected R1 score of 14 which daily decisions wa required one persoo mobility, transfers hygiene, toileting, Review of the corr Michigan, dated 2/ medication admini blood sugars. Review of the Grid through 3/28/23, re concerns with med Requested Nursing "A" for R1's Griev months via email of 9:56 a.m., reflected locate R1 Grievan medication concer Review of the mon Minutes, dated Oc 2023, reflected res timeliness of medi 12/30/22, 1/27/23 months requested) During an intervie NHA "A" reported concern forms or e monthy resident c concerns October 1 including reported medications.	had a BIM (assessment tool) indicated her ability to make is cognitively intact, and she on physical assist with bed , locomotion on unit, dressing, and bathing. nplaint submitted to the State of /13/23, reflected concerns with istration and monitoring of evance Log, dated 1/1/23 eflected R1 had reported dication timeliness on 2/6/23. g Home Administrator (NHA) rances Forms for past three on 3/30/23 at 9:20a.m. rom NHA "A", dated 3/30/23 at d NHA "A" was unable to ce dated 2/6/23 related to ns. nthly Resident Council Meeting tober 2022 through March idents reported concerns about cation administration on and 3/27/23(three of six w on 3/30/23 at 10:20 a.m., 1 the facility did not have any evidence of follow up for rouncil meetings reported 2023 through February 2023 resident concerns for late		biweek Audit re monthly attends The Ad	ly for 4 weeks and then mo soults will be reviewed at th y QAPI meeting that the Ac ministrator is responsible f	onthly. ne facilities dministrator	

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:			ISTRUCTION		ATE SURVEY LETED
		384200	B. WING _			3/30/2	023
NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MISSION POIN	IT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	R1 received physic on 53 occasions. T administered medi CD (treatment of a hours late accordir reported reflected (fast acting insulin ordered prior to ea Review of R1 EM reflected no evider medications and in other late physicia During an intervie Director of Nursin expect if residents medication timing if not given as orde documentation cor reported would exp hour prior or one F time of administra During an observa at 3:45 p.m., R1 ve with medication timic complaints made t reported usuall staff. Resident #2(R2) Review of the Facc (MDS) dated 3/8/2 old female admitte with diagnoses tha blood pressure), cf	R, dated 2/1/23 through 2/6/23, nee of physician notified of late histration including cardiac usulin for blood sugar or several ns ordered medications. w on 3/30/23 at 2:50 p.m. g (DON) "B" reported would reported concerns with an infestation should occur and ered physician notified and npleted in EMR. DON "B" pect medication to be given one iour after physician ordered					

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDIN		ISTRUCTION		ATE SURVEY LETED
		384200	B. WING _			3/30/2	2023
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRC DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	BIM (assessment findicated her abili cognitively intact, physical assist wit locomotion on uni and bathing. R2 M behaviors. During an observa at 12:30 pm, R2 w wheelchair, appear without difficulty. staff transport R2 wheelchair just pri with agency staff v medications to her about 3 weeks prio was completed and was given to her a without their know nurse the morning medication and in Review of R2 Inci 3/4/23 at 10:11 a.r approached this nu med pass and aske florescent pink pil last night were. Aff MAR and verifyin out were bright pin medications. The of that I found contai our "complete alle pills to the residen were in fact the pi the night before. N vitals are WNL an	he MDS reflected R2 had a tool) score of 14 which ty to make daily decisions was and she required one-person h bed mobility, transfers, t, dressing, hygiene, toileting, IDS reflected no evidence of tion and interview on 3/30/23 ras in room sitting in red able to answer questions This surveyor had observed from Dining room to room via ior. R2 reported did have issue who administered wrong and other residents on the hall or. R1 reported investigation d determined to be Benadryl nd other residents on the hall vledge. R2 reported told her after R2 received unknown vestigation was done. dent/Accident report, dated n., reflected, "Resident urse this morning during am d me if I knew what the "two ls" that she got with her meds frer going through the residents g that none of the meds signed ak I looked at our stock only bottle of OTC medications ning florescent pink pills were rgy relief". I presented these t and she verified that they lls she had received in her meds fursing assessment completed d patient has no complaints of nd is currently stable. DON medication error."					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		DATE SURVEY
		384200	B. WING _		3/30/	2023
NAME OF PRO	VIDER OR SUPPLIE	R		STREET ADDRESS, CIT	Y, STATE, ZIP CO	DDE
MISSION PO	INT HEALTH CAN	IPUS OF JACKSON		703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE CORRECTIVE ACTION SHOUI REFERENCED TO THE APF DEFICIENCY)	_D BE CROSS-	(X5) COMPLETIO DATE
	current (3/30/23),	ysician orders, dated 3/1/23 to with no evidence of an order rgy Relief (Benadryl).				
	p.m., Licensed Pra reported R2 report that she had receiv the night prior tha "K" reported R2 c morning. LPN "K identify pink tabs when visually sho informed NHA "A "L". LPN "K" rep R2 along with oth	e interview on 3/30/23 at 12:58 actical Nurse (LPN) "K" ed to her on morning of 3/4/23 ved two fluorescent pink pills t she did not recognize. LPN omplained of feeling sleepy that ' reported R2 was able to she had received were Benadryl wn tabs. LPN "K" reported " who reported to regional staff orted was instructed to monitor er residents on the hall and e some other residents who rning.				
	Director of Nursin hired as Assistant month ago and wa two weeks. DON to her 3/4/23 that 1 concerns from nig had complained to tired on 3/4/23. Do was completed an night of 3/3/23 wh reported facility h- to return to the fac "B" reported no re Benadryl and only reported found in had not been prior medication carts. I identified that one to compete all meat timely in two hour medications and fi	w on 3/30/23 at 1:41 p.m., g (DON) "B" reported was Director of Nursing about one s now interim DON for past "B" reported LPN "K" reported R2 reported medication ht prior. DON "B" reported R2 LPN "K" about being extra ON "B" reported investigation d determined was agency nurse to was questioned. DON "B" ad not allowed that agency staff ility after the incident. DON sidents had an order for on hand for allergy and medication room opened and and verified not kept on DON "B" reported had nurse on 200 hall is impossible dication and treatment orders to because too many equency of treatments and bostly an issue with agency				

STATEMENT OF DEFICIENCI ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 384200	Á. BUILDI	TIPLE CONSTRUCTION NG	COMP	ATE SURVEY LETED 1023
IAME OF PROVIDER OR SUF		 	STREET ADDRESS, CIT 703 ROBINSON RD JACKSON, MI 49203		DE
PRÉFIX (EACH DEF	STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY JLATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR CORRECTIVE ACTION SHOU REFERENCED TO THE AP DEFICIENCY)	LD BE CROSS- PROPRIATE	(X5) COMPLETION DATE
SS= D §483.45(g) I Drugs and b must be lab accepted pri the appropri instructions, applicable. § Biologicals § State and Fe store all drug compartmer controls, and personnel to §483.45(h)(3 separately lo compartmer listed in Sch Drug Abuse 1976 and ot except when package dru the quantity dose can be This REQUI evidenced b This citation MI00135247. Based on obs review the fa three resident were stored p resulting in th	Drugs and Biologicals abeling of Drugs and Biologicals ologicals used in the facility led in accordance with currently ofessional principles, and include ate accessory and cautionary and the expiration date when 483.45(h) Storage of Drugs and 483.45(h)(1) In accordance with ederal laws, the facility must gs and biologicals in locked ts under proper temperature I permit only authorized have access to the keys. 2) The facility must provide cked, permanently affixed ts for storage of controlled drugs edule II of the Comprehensive Prevention and Control Act of her drugs subject to abuse, the facility uses single unit g distribution systems in which stored is minimal and a missing readily detected. REMENT is not met as V: pertains to intake number	F0761	Element #1 There are no medications stor #3 room. Resident #3 was edu to properly store medications 5/1/2023. Element #2 Residents that are care planner suppository insert and digital s risk of being affected by the du All residents were assessed for self-administer medication by Element #3 The director of nursing was re the regional director of clinical storage in the facility policy ar administration policy on 4/27/2 The Director of Nursing/design the nursing staff medication st facility policy and the self-adm policy. A QAPI meeting was held on - determine the root cause. Any nurse not educated by 5/2 educated at the beginning of t prior to working. Element #4 Director of Nursing/Designee - audit on all residents that have assessed to self-administer m proper storage of medications weeks, biweekly x4 weeks, m Audit results will be reviewed monthly QAPI Committee med Administrator attends. The Administrator is responsit and sustaining compliance.	ucated on how in room on ed to utilize a stimulator are at eficit practice. or the ability to 5/5/2023. -educated by on medication ad the self- 2023. hee re-educated torage in the hinistration 4/24/23 to 5/2023 will be heir next shift will complete an e been edications for weekly x 4 onthly. at the facilities eting that the	5/5/2023

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		384200	B. WING _			3/30/2023		
NAME OF PROV	IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE	
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE	
		e sheet Resident #3 (R3) was ility on 3/4/2022. Diagnosis ion.						
	revealed R3 had an Bowel Program us (insertion of finger of the daily Bisacct the rectum in order wait 10-15 min the rectal wall (touch/ rectum for 20-30 s evacuation of the H 10-15 min up to 4 care program." Review of another 5/13/2022, reveale "Bisacodyl Suppor Insert 10 mg rectal constipation hold i Another active car "Focus" of, "I (R3 daily living) Self O Deficit r/t (related SECONDARY TO dated 3/4/2022 and interventions in pl. Program using Sup Digital Rectal stimulat around the wall of to help stimulate e contents. Repeate e Encourage me (R3 dated 6/15/2022 and	an's orders dated 6/15/2022, n order in place for, "Daily ing Digital Rectal stimulation r into rectum). After insertion dyl suppository (inserted into r to cause a bowel movement), en do digital simulation of tap around the wall of the econds) to help stimulate bowel contents. Repeat every times. one time a day for bowel Physician's order dated d an order for R3 to receive, sitory 10 MG (milligrams) lly in the morning for f loose stools." e plan in place revealed a) have an ADL (activities of Care and mobility Performance to) QUADRIPLEGIA) cervical spinal cord injury." d revised on 10/5/2022. The ace included, "Daily Bowel opository insertion device and uluation. After insertion of the ppository, wait 10-15 min then ion of rectal wall (touch/tap the rectum for 20-30 seconds) vacuation of the bowel very 10-15 min up to 4 times. b) to do this independently." here the "Position" responsible						

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:	A (X2) MULTII A. BUILDING		ISTRUCTION		(X3) DATE SURVEY COMPLETED	
		384200	B. WING _				2023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY,	STATE, ZIP CC	DE	
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
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	of care with a "Fod a self-suppository stimulator.", dated 12/19/2022. The c of, "I (R3) have a j suppository inserti rectal stimulator do order to self admir perform self rectal myself per my req revised on 12/19/2 "Position" revealed performed by a Re Licensed Practical of, "nursing to get insertion device for rectum." dated 12/ the intervention way perform. The care intervention to, "P the adaptive bowe my being as indep 12/19/2022, and ur was assigned to an In an observation a 12:56 PM, R3 statt his bowel program suppository every insert the supposit he did have the de bowel program an himself, but said th himself because he and also did not no further stated that stimulation every in Certified Nurse Ai	re plans revealed an active plan cus" of, "Bowel Program using inserter, and self-rectal 11/2/2022 and revised on are plan included interventions personal adaptive rectal on device and an adaptive evice (device for R3 to use in hister the suppository and stimulation) that I will use on uest.", dated 11/2/2022 and 2022. The intervention, under d that the intervention was to be gistered Nurse (RN) or Nurse (LPN). An intervention bowel suppository into the or me (R3) to insert not (sic) my (19/2022, and under "Position" as assigned to an RN or LPN to plan revealed another lease encourage me (R3) to use I care devices daily to aide in endent as possible." dated nder "Position" the intervention a RN/LPN to perform. and interview on 3/29/2023 at ed that his biggest concern was h. R3 said he received a morning, but was not able to ory himself. R3 also stated that vice so he could perform his d insert the suppository hat he could not use the device e could not reach his rectal area, pw how to use the device. R3 he was supposed to have rectal morning, however stated di (CNA) "E" was the only one his suppository to him, and that d not. ew with R3 observation was						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		384200	B. WING _			_ 3/30/2	2023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE	
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
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	to be in R3's bathr	room. The device was observed oom medicine cabinet, in a with several Bisacodyl						
	"E" said she admin digital rectal stimu there was no set ti suppository or per CNA "E" said the own suppository a stimulation he was further stated that were stored in R3' cabinet. CNA "E"	3/29/2023 at 2:32 PM, CNA nistered R3 his suppository, and ulation every morning, but said me to administer the form the rectal stimulation. device R3 had to perform his dministration, and bowel s not able to use. CNA "E" the Bisacodyl suppositories s bathroom in the medication also stated that she did not tell he administered R3's						
	"C" stated, upon a administered R3's bowel stimulation, his suppository an stimulation. At 8:0 with LPN "C", CN the floor with app suppositories on th packaging. LPN "C "E" that she could Bisacodyl supposi in which CNA "E" asked R3 if she co suppository howev he was comfortabl no he was not, and administered his E LPN "C" then was but LPN "C" was a suppositories CNA	3/30/2023 at 7:50 AM, LPN sking the question of who suppository and performed his , that nursing administered R3 d performed the bowel 5 AM upon entering R3's room IA "E" was observed sitting on roximately six Bisacodyl ne floor next to her still in the C" made a comment to CNA see that CNA "E" had tories next to her on the floor, ' replied "yes". LPN "C" then uld administer him his yer, CNA "E" then asked R3 if e with that, in which he stated I that CNA "E" always Bisacodyl suppository to him.						

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:		A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		384200	B. WING _			3/30/2	2023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CC	DDE	
MISSION PO	INT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
	stated she did not administering R3 digital rectal stimu "E". RN "I" further suppositories were was in the locked locked and stores has a key to open) that the medicatio In an interview on "D", who was also nurses were to adn suppository, and a was a CNA to adn LPN "D" said she administering R3 stated that medica resident's room. L suppositories were medication room in Director of Nursir was not to admini- and said not even she was not aware administering R3 suppositories were that both were ina Per the facility po "MEDICATION S FACILITY" DAT under, "STORA MEDICATIONS. are stored safely, s following manufa	3/30/2023 at 12:12 PM, LPN o the Unit Manager, stated that ninistered R3 his Bisacodyl lso stated that "absolutely not" ninister resident's medications. was not aware CNA "E" was his Bisacodyl suppository, and tions were not to be stored in PN "D" said Bisacodyl e to be locked up in the nside the refrigerator. 3/30/2023 at 12:41 AM, g (DON) "B" stated that a CNA ster medications to a resident, a suppository. DON "B" said CNA "E" had been his suppository, nor that the e kept in his room, and stated ppropriate. licy and procedure titled, STORAGE IN THE ED JUNE 2019, revealed						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 384200		À. BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 3/30/2023	
(X4) ID	SUMMARY ST		ID	STREET ADDRESS, CITY, STATE, ZIP CODE 703 ROBINSON RD JACKSON, MI 49203 PROVIDER'S PLAN OF CORRECTION (EACH				
PREFIX TAG	accessible only to pharmacy technic "B. Only nurses, p technicians are pe Medication rooms	NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION) nurses, pharmacists, and ians.", and under "Procedures", oharmacists, and pharmacy rmitted to access medications. c, carts, and medication supplies ot attended by persons with "	PREFIX TAG		RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIO DATE	
F0839 SS= E	qualifications. §4 employ on a full- basis those prof- out the provision §483.70(f)(2) Pr licensed, certifie accordance with This REQUIREN evidenced by: This citation perta MI00135247. Based on observa review the facility three residents (R suppository was a resulting in the po- improper adminis side effects not be Findings Include: Per the facility fac admitted to the fa- included constipal Review of Physic revealed R3 had a Bowel Program u	ns §483.70(f) Staff 483.70(f)(1) The facility must time, part-time or consultant essionals necessary to carry is of these requirements. ofessional staff must be d, or registered in applicable State laws. MENT is not met as ins to intake number tion, interview, and record failed to ensure for one out of esident #3) that a daily diministered by a licensed nurse, tential for medication errors, tration, and the potential for ing recognized or reported. es sheet Resident #3 (R3) was cility on 3/4/2022. Diagnosis ion. tan's orders dated 6/15/2022, n order in place for, "Daily sing Digital Rectal stimulation r into rectum). After insertion	F0839	C.N.A. J Elemen Resider supposi by the c C.N.A E audited supposi Elemen The dira the regi for C.N. The Dir the nurs C.N.As. A QAPI determi Any nur will be e shift prio Elemen Director audit 20 supposi nurse w then mod	was educated on the duties for bosition on 4/28/2023. t #2 the that C.N.A E works with that tories have the ability to be affec- leficit practice. Res that work with that receive a suppository wer regarding who inserts their tories by 5/5/2023. t #3 actor of nursing was re-educate onal director of clinical on the d A.s on 4/27/2023. ector of Nursing/designee re-ec- ses and C.N.A on the duties for meeting was held on 4/24/23 to ne the root cause. se or C.N.A not educated by 5/ educated at the beginning of the or to working. t #4 of Nursing/Designee will randor % of the residents that receive tories that they were provided to reekly x 4 weeks, biweekly x 4 weeks, source to the second to the the second to the second the the second to the se	d by utilize d by uties lucated 5/2023 pir next omly oy a weeks, iilities	5/5/2023	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE	
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
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	of the daily Bisacc the rectum in orde wait 10-15 min the rectal wall (touch/ rectum for 20-30 s evacuation of the l contents. Repeat e one time a day for Review of another 5/13/2022, reveale "Bisacodyl Suppo: Insert 10 mg recta constipation hold i Record review of 1 record (MAR) for February, and Mar mentioned physici on R3's MARs in ' signed by initial th and Bisacodyl sup administered. Another active car "Focus" of, "I (R3 daily living) Self O Deficit r/t (related SECONDARY TO injury." dated 3/4/ The interventions Program using Sup Digital Rectal stin daily Bisacodyl su	odyl suppository (inserted into r to cause a bowel movement), en do digital simulation of tap around the wall of the seconds) to help stimulate bowel very 10-15 min up to 4 times. bowel care program." Physician's order dated d an order for R3 to receive, sitory 10 MG (milligrams) lly in the morning for		The Ad	strator attends. ministrator is responsible for att staining compliance.	aining		
	seconds) to help st	the rectum for 20-30 timulate evacuation of the epeat every 10-15 min up to 4 me (R3) to do this						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		384200	B. WING _			3/30/2023	
NAME OF PROV	/IDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	independently." da 12/19/2022. The ir "Position" respons Review of R3's car of care with a "Foo a self-suppository stimulator.", dated 12/19/2022. The c of, "I (R3) have a j suppository inserti rectal stimulator di order to self admir perform self rectal myself per my req revised on 12/19/2 intervention, unde intervention was to Nurse (RN) or Lic An intervention of suppository into the to insert not (sic) r and under "Positio assigned to an RN plan revealed anot encourage me (R3) devices daily to ai as possible." dated "Position" the inte RN/LPN to perfor In an observation a 12:56 PM, R3 stat his bowel program	tted 6/15/2022 and revised on ttervention revealed the ible was an RN/LPN. re plans revealed an active plan cus" of, "Bowel Program using inserter, and self-rectal 11/2/2022 and revised on are plan included interventions personal adaptive rectal on device and an adaptive evice (device for R3 to use in inster the suppository and stimulation) that I will use on uest.", dated 11/2/2022 and 022. The r "Position" revealed that the o be performed by a Registered ensed Practical Nurse (LPN). , "nursing to get bowel te insertion device for me (R3) ny rectum." dated 12/19/2022, n" the intervention to, "Please) to use the adaptive bowel care ther intervention to, "Please) to use the adaptive bowel care de in my being as independent 12/19/2022, and under rvention was assigned to an m. and interview on 3/29/2023 at ed that his biggest concern was b. R3 said he received a			DEFICIENCY)		
	insert the supposit he did have the de bowel program and himself, but said th	morning, but was not able to ory himself. R3 also stated that vice so he could perform his d insert the suppository nat he could not use the device e could not reach his rectal area,					

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	and also did not not further stated that is stimulation every in Certified Nurse Aai who administered licensed nurses did During the intervior made in R3's bath to be in R3's bath to be in R3's bath plastic bag along v suppository's. R3 continued to staneed the rectal since cNA "E" was the performed this for also stated that ever working on her day facility in his room him his suppositor In an interview on "E" said she admir digital rectal stimut there was no set the suppository or performed that suppository or performed that suppository or performed that were stored in R3's cabinet. CNA "E" the nurses when sh suppository. In an interview on stated that R3' bow to him a supposito	ow how to use the device. R3 he was supposed to have rectal morning, however stated d (CNA) "E" was the only one his suppository to him, and that l not. ww with R3 observation was oom. The device was observed oom medicine cabinet, in a with several Bisacodyl ate that he was constipated and timulation every morning, and only staff member who him when he would ask. R3 en when CNA "E" was not ys off, she would be at the h, and even the administered					
		d R3 his suppository. 3/30/2023 at 7:50 AM, LPN					

STATEMENT O AND PLAN OF (F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER:			ISTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DE	
MISSION POI	NT HEALTH CAN	IPUS OF JACKSON			703 ROBINSON RD JACKSON, MI 49203			
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	administered R3's bowel stimulation, his suppository an stimulation. At 8:0 with LPN "C", CN the floor with appr suppositories on tf packaging. LPN "C" "E" that she could Bisacodyl supposi in which CNA "E" asked R3 if she co suppository howev he was comfortabl no he was not, and administered his B LPN "C" then was but LPN "C" was of suppositories CNA of R3' room leavin "E". In an interview on stated she did not 1 administering R3 1 digital rectal stimu "E". RN "I" furthe suppositories were was in the locked 1 locked and stores 1 has a key to open) that the medication RN "I" additionall CNA "E" administ suppository. In an interview on "D", who was also	sking the question of who suppository and performed his that nursing administered R3 d performed the bowel 5 AM upon entering R3's room IA "E" was observed sitting on oximately six Bisacodyl the floor next to her still in the C" made a comment to CNA see that CNA "E" had tories next to her on the floor, replied "yes". LPN "C" then uld administer him his ver, CNA "E" then asked R3 if e with that, in which he stated that CNA "E" always tisacodyl suppository to him. observed to exit R3's room, observed to exit R3's room, observed to not take the A "E" had in her possession out g the medication with CNA 3/30/2023 at 8:24 AM, RN "I" know who had been nis Bisacodyl suppository, and lation to him other than CNA r stated that Bisacodyl to be in the refrigerator that medication room (room that is medications that only the nurse because the facility policy was n was locked up. y stated that she had observed ter R3 his Bisacodyl 3/30/2023 at 12:12 PM, LPN the Unit Manager, stated that ninistered R3 his Bisacodyl						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		384200	B. WING _			3/30/2	2023
	VIDER OR SUPPLIE	I R IPUS OF JACKSON			STREET ADDRESS, CITY, STAT 703 ROBINSON RD JACKSON, MI 49203	E, ZIP CO	DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C :FERENCED TO THE APPROPRI/ DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	was a CNA to adm LPN "D" said she administering R3 I stated that medical resident's room. Ll suppositories were medication room i In an interview on Director of Nursin was not to adminis and said not even a she was not aware administering R3 I suppositories were that both were inap Review of the faci titled, "MEDICAT GENERAL GUID revealed under " Preparation 1) Me licensed nursing, r personnel.", and "J Medications are ac nursing or medical Review of a CNA signed on 2/28/202	lity's policy and procedure ION PREPARATION- ELINES" dated June 2019, PROCEDURES", "A. dications are prepared only by nedical, or pharmacy B. Administration 1) lministered only by licensed l personnel." job description that CNA "E" 22, revealed no language in a tion for CNAs to administered					