STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	524050	A. BUILDING _____ B. WING _____	**1/3/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION POINT NSG & PHY REHAB CTR OF ISHPEMING	**435 STONEVILLE RD ISHPEMING, MI 49849**

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F0000 SS=	INITIAL COMMENTS Mission Point of Ishpeming was surveyed for an Abbreviated survey on 1/3/2024 Intakes: MI00140614, MI00140558, MI00139839, MI00139938, MI00137469, MI00136876, MI00136762 Census= 44	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of	F0550	Element 1: Resident R1 Still resides in the facility. On 9-29-2023 SSW met with R1 conducted a psycho-social well-being visit. During this visit R1 indicated that he did not remember anything eventful taking place, and no ill - effects were noted taking place from staff. Will continue to observe for ill-effects. CNA was a Travel CNA and was suspended pending investigation and later her position was terminated. Element 2: All residents have the potential to be affected. Guardian Angel audits have been completed to ensure for this Resident to ensure that positive communication is occurring and Residents needs are being met from nursing staff/staff. Element 3: NHA and DON have reviewed resident□s rights and abuse policies and deemed them appropriate. The DON/Designee will re-educate nursing staff regarding resident□s rights and dignity. NHA/DON will re-educate all staff on abuse policy and reporting abuse and dignity. Element 4: The DON/Designee will meet with R1 weekly for 30 days to ensure that positive communication is taking place between R1	1/31/2024

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

Electronically Signed | 01/26/2024

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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	interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This deficiency pertains to #MI00139839. Based on observation, interview, and record review, the facility failed to ensure care was provided in a dignified and respectful manner for one Resident (R1) of three residents reviewed for dignity. This deficient practice resulted in the disrespectful treatment of R1 and the potential for feelings of anger and humiliation. Findings include: Resident #1 (R1) was admitted to the facility on 11/08/2017 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD), muscle weakness, abnormalities of gait and mobility, osteoarthritis, chronic respiratory failure with hypoxia, and others. R1 had a significant change Minimum Data Set (MDS) assessment on 10/2/2023. The MDS documented R1 as requiring substantial/maximal assistance from staff with toileting hygiene, dressing the lower body, transfers to/from chair and bed, toileting transfers, and positional changes (sit to lying position, lying to sitting on the side of the bed, and sitting to standing position). According to the Care Area Assessment worksheet, R1 had an Activities of Daily Living (ADL) deficit due to activity intolerance, fatigue, limited mobility, COPD, chronic pain, and decreased range-of-motion to bilateral (both sides) hips. A staff-to-resident incident was reported to the		and nursing staff/staff are provided will be reviewed by DON/designee and addressed immediately. Results will be reported to the QAPI committee for further review and recommendations. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 1/31/24, and for sustained compliance thereafter.	

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	State Agency on 9/28/2023 at 5:44 p.m., and the facility investigation into the incident was submitted to the State Agency on 10/6/2023 at 5:11 p.m. An undated investigation signed by a previous Director of Nursing (DON) who is no longer employed at the facility documented a verbal altercation by Certified Nursing Assistant (CNA) "T" toward R1 that occurred on 9/28/23 at 3:45 p.m. According to the investigation, Licensed Practical Nurse "L" (LPN "L") observed CNA "T" during the provision of care for R1. LPN "L" observed R1 attempting to independently remove an incontinence product but "was not cooperating" per the investigation. LPN "L" witnessed R1 throw the soiled incontinence product at CNA "T." CNA "T" said "You're an asshole and something else." CNA "T" then turned and noticed LPN "L" standing in the doorway. CNA "T" apologized and exited the room. The investigation documented CNA "T" was terminated from employment. On 1/2/23 at 12:13 p.m., R1 was observed in his room. R1 was alert and answering questions appropriately. R1 was in a left side-lying position and was wearing a nasal cannula (a device to deliver supplemental oxygen). R1's room environment was untidy with numerous tissues and debris on the floor. Foodstuff was scattered around R1 and on R1's overbed table. The garbage receptacle was filled with refuse, and there were 2 urinals hung on the edge of the garbage can. One of the urinals was filled with urine. R1 conveyed to the surveyor that staff do not answer the call light or assist him when he needs help. When asked regarding staff treatment, R1 stated, "Some are ok but sometimes they're assholes." R1 said this has resulted in a request to social services for assistance with placement at another facility. R1 said he could not specifically recall a staff member using cursory words or profanity toward him in September of 2023.			

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	The facility social services employee, (Staff "A") was interviewed on 1/3/24 at 9:06 a.m. Staff "A" confirmed a staff member was verbally inappropriate to R1. Staff "A" described the staff member as "a newer CNA - I can't recall her name." Staff "A" stated the CNA told R1 to "eat shit" when he made an inappropriate comment to the CNA. Staff "A" said R1 wanted to transfer to a different facility and referrals were sent to other facilities to try and accommodate R1's desire to leave the facility. LPN "L" was interviewed on 1/3/24 at 10:42 a.m. LPN "L" said she recalled the occurrence of 9/28/23 and said she provided a written statement about the incident to the previous DON. LPN "L" said she walked into R1's room while R1 was in the bathroom on the commode. CNA "T" was in the bathroom with R1 and they "had inappropriate words." When asked to explain "inappropriate word," LPN "L" said she could not specifically recall and told the surveyor, "Read my statement." LPN "L" said CNA "T" left the room. LPN "L" said R1 was angry when exchanging words with CNA "T" and remained angry when CNA "T" left the room. LPN "L" said she reported the occurrence to the DON at the time. A handwritten statement dated 9/28/23 at 15:45 (3:45 p.m.) and signed by LPN "L" was reviewed. The statement read in part: "[CNA "T"] was in the doorway of the B.R. (bathroom) trying to get [R1's] incontinent product out from underneath him, however he was not cooperating. I seen the incontinent product land in front of [CNA "T"] soiled with stool. [CNA "T"] stated 'you're an asshole' and something else. [CNA "T"] turned and seen nurse standing there and apologized." Unreturned phone calls were made to CNA "T" on 1/3/24. The facility investigation of the incident between CNA "T" and R1 contained a			

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	handwritten, signed statement by CNA "T." The statement read in part "[R1] started to try to put the brief in the toilet and I told him that would mess up the toilet and when I reached for the brief he grabbed the brief and threw it at me and also threw his feces at me, I responded 'Stop, eat shit!'			
F0725 SS= F	Sufficient Nursing Staff §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: This deficiency pertains to Intake #MI00139839. Based on observation, interview, and record review, the facility failed to provide sufficient numbers of nurse aides to provide adequate care to the resident population in accordance with the	F0725	Element 1: No residents were cited by the deficient practice in the 2567. Element 2: All residents have the potential to be affected. Facility Assessment has been reviewed and updated to current resident care acuity. Element 3: Ishpeming is recruiting with advertisements on Indeed, LinkedIn, and Michigan Works. The facility has implemented a pickup bonus for current staff. Ishpeming utilizes staff from a float pool of nursing staff within Mission Point Corporate. Nursing management has and is picking up shifts on a routine basis to ensure that scheduled staff do not get overwhelmed. Ishpeming is currently de-licensing its beds from 63 to 39 and admissions have been temporarily on hold. DON/Designee provided re-education related to the attendance and punctuality Policy. Element 4: The DON/Designee will audit nurse and CENA staffing schedules/assignments to ensure facility is maintaining minimum amount of staffing per the facility assessment shift 2x a week for 4 weeks then monthly 2x for 3 months. Any concerns will be reviewed by the DON/Designee and addressed immediately. Ishpeming HR/Designee will provide a report weekly for 4 weeks then monthly for 4 weeks to document recruitment of new facility staff. The DON/Designee will report the results to the monthly Quality Assurance Performance	1/31/2024

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	facility assessment. This deficient practice has the potential for unmet care needs and the provision of inadequate care for all 44 residents in the facility. Findings include: Resident #1 (R1) was admitted to the facility on 11/08/2017 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (COPD), muscle weakness, abnormalities of gait and mobility, osteoarthritis, chronic respiratory failure with hypoxia, and others. R1 had a significant change Minimum Data Set (MDS) assessment on 10/2/2023. The MDS documented R1 as requiring substantial/maximal assistance from staff with toileting hygiene, dressing the lower body, transfers to/from chair and bed, toileting transfers, and positional changes (sit to lying position, lying to sitting on the side of the bed, and sitting to standing position). According to the Care Area Assessment (CAA) worksheet, R1 had an Activities of Daily Living (ADL) deficit due to activity intolerance, fatigue, limited mobility, COPD, chronic pain, and decreased range-of-motion to bilateral (both sides) hips. On 1/2/23 at 12:13 p.m., R1 was observed in his room. R1 was in a left side-lying position and was wearing a nasal cannula (a device to deliver supplemental oxygen). R1's room environment was untidy with numerous tissues and debris on the floor. Foodstuff was scattered around R1 and on R1's over-bed table. The garbage receptacle was filled with refuse, and there were 2 urinals hung on the edge of the garbage can. One of the urinals was filled with urine. R1 conveyed to the surveyor that staff do not answer the call light or assist him when he needs help. R1 stated, "they need more help around here." Resident #4 (R4) was admitted to the facility on 10/1/15 with diagnoses including but not limited		Improvement [QAPI] committee who will determine what further action, if any, is necessary to maintain substantial compliance. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 1-31-24 and for sustained compliance thereafter.	

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	to: post-traumatic stress disorder, unsteadiness on feet, muscle weakness, blindness of the left eye, obesity, arthritis, chronic pain syndrome, and others. R4 had a quarterly MDS assessment completed on 11/24/2023. The MDS documented R4 as requiring moderate/partial assistance from staff for showering, lower body dressing, toilet transfers, tub/shower transfers, chair/bed-to-chair transfers, and positional changes from a sitting to standing position. During an interview on 1/2/23 at 2:50 p.m., R4 said "Staffing here is really bad." R4 said there were extended periods of time before call lights were answered in the facility due to not having enough staff on duty. R4 said staffing was not consistently sufficient to provide R4 with showers on Sundays and Wednesday according to R4's shower schedule. R4 said she received "quick sponge baths in the bed" in lieu of showers due to short-staffing concerns. R4 told the surveyor, "They are cutting staff - we only have one aide [nurse aide] sometimes. How is one aide going to help all these people?" When asked if she could recall a day only one nurse aide was on duty, R4 replied, "On Christmas - last week." A review of R4's shower task records for the month of December 2023 recorded R4 as having 1 shower during the month, on 12/27/23. The record showed R4 as receiving baths on 12/6/23, 12/10/23, 12/13/23, 12/17/23, 12/20/23, 12/24/23, and 12/31/23. Neither task records nor nurse progress notes document the reason R4 received baths in lieu of showers on those dates. On 1/3/23 at 8:37 a.m., Licensed Practical Nurse (LPN)"N" was interviewed regarding staffing. LPN "N" said she worked twelve-hour shifts 1-2 days per week providing direct care in a nurse aide capacity due to staffing concerns with CNAs (Certified Nursing Assistants). LPN "N" said she			

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	heard residents make comments concerning the lack of adequate numbers of CNAs in the facility. On 1/3/23 at 8:40 a.m., CNA "O" was interviewed regarding staffing. CNA "O" stated she has worked in the facility for 7 years and "staffing is up and down - sometimes we have full staff, sometimes we're short." CNA "O" said on Christmas day there was 1 CNA in the building for an entire shift. CNA "O" said LPN "P" (the facility wound nurse) came to work in the facility on Christmas day to help due to an insufficient number of staff in the building. CNA "O" stated, "This happens a lot recently. On 1/3/23 at 8:45 a.m., CNA "M" was interviewed regarding staffing. When asked about staffing on Christmas, CNA "M" said there was one aide that worked on Christmas Day from 6:30 a.m. - 3:00 p.m. CNA "M" said she worked 12 hours on Christmas Eve and "was alone from 2:30 p.m. to 6:30 p.m. until someone else showed up to work." CNA "M" said, "[name of LPN "P"] came in to help somewhat" on Christmas day. On 1/3/23 at 8:55 a.m., LPN "P" was interviewed regarding staffing. LPN "P" confirmed coming into work on Christmas day. When asked what duties he completed on 12/25/23, LPN "P" said wound care was completed for the day and added, "I also helped out on the floor for a while." When asked about staffing on 12/25/23, LPN "P" stated, "I don't remember how many CNAs were here." The Facility Assessment was reviewed. The revision history to the assessment documents the assessment was "updated to clinical accuracy" on 2/18/2023. The most recent revision date was 8/17/23 and documented the revisions on that date as "updated for new administrator, no clinical update." The CNA staffing number required to render care for the facility population			

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	of residents was documented in the Facility Assessment as "10-14 per day." The facility scheduler (Employee "S") provided a 12/25/23 shift schedule form. According to the shift schedule form, 2 CNAs worked on the day shift (from 6:30 a.m. - 3:00 p.m.), 3 CNAs worked the afternoon shift (from 2:30 p.m. - 11:00 p.m.), and 2 CNAs worked the night shift (from 10:30 p.m. - 7:00 a.m.) on Christmas day. The CNA shift schedule for 12/25/23 documented a total of 7 CNAs for the day on 12/25/23, not the 10 - 14 CNAs that are required to care for the residents according to the facility assessment. A time clock punch-detail report was requested. According to the CNA time clock punch-detail report for 12/25/23, there were 2 CNAs on the day shift, 1 CNA on the afternoon shift, and 1 CNA on the night shift for a total of 4 CNAs who punched the time clock to work on 12/25/23. The punch-detail report did not match the shift schedule form that had been provided by Employee "S." On 1/3/24 at 12:51 p.m., the time clock punch-detail report was reviewed with the Administrator (NHA). The NHA was asked if the CNA staffing on 12/25/23 was sufficient to meet the needs of the residents in the facility. The NHA shook his head and stated, "That's all we could get." The NHA said it was possible a traveling "company pool" staff or agency staff worked on 12/25/23 and said the shift schedule form would include everyone who worked on 12/25/23. The 12/25/23 shift schedule form was reviewed with the NHA and Employee "S." When asked to explain the discrepancy between the number of CNAs documented on the shift schedule form versus the number of CNAs who punched the time clock, Employee "S" admitted that one of the			

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	names documented on the shift schedule form under the CNA section was the facility wound nurse, LPN "P." According to Employee "S", the other name documented on the shift schedule form in the CNA section for afternoon shift on 12/25/23 was CNA "M." Employee "S" said CNA "M" stayed over onto the afternoon shift after working on the day shift. Employee "S" was shown the time clock punch-detail report that showed CNA "M" punched out of work at 3:07 p.m. on 12/25/23, 37 minutes into the afternoon shift. Employee "S" offered no comment or explanation. Employee "S" said the staffing on 12/25/23, 4 total CNAs for 3 shifts, was sufficient to care for all 44 residents in the facility. LPN "P" was also documented on the shift schedule form as one of the CNAs on the night shift of 12/25/23. Neither the shift schedule form nor the time clock punch-detail report for 12/25/23 reflected the 10-14 CNAs necessary per day to render care to the residents in the facility in accordance with the resident population according to the facility assessment.			