GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

May 16, 2022

Emery Dumas
Mission Point Health Campus of Jackson
703 Robinson Rd.
Jackson, MI 49203-2538

RE: License #: AH380301277
Investigation #: 2022A1027051
Mission Point Health Campus of Jackson

Dear Mr. Dumas:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- Indicate how continuing compliance will be maintained once compliance is achieved.
- Be signed by the authorized representative and dated.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 241-1970.

Sincerely,

Jessica Rogers

Jessica Rogers, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(517) 285-7433
enclosure

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH380301277
Investigation #:	2022A1027051
Complaint Receipt Date:	04/19/2022
Investigation Initiation Date:	04/19/2022
Report Due Date:	06/19/2022
Licensee Name:	Mission Point Health Campus of Jackson, LLC
Licensee Address:	30700 Telegraph Road Bingham Farms, MI 48205
Licensee Telephone #:	(502) 213-1710
Administrator:	Laurie McCullough-Benner
Authorized Representative:	Emery Dumas
Name of Facility:	Mission Point Health Campus of Jackson
Facility Address:	703 Robinson Rd. Jackson, MI 49203-2538
Facility Telephone #:	(517) 787-5140
Original Issuance Date:	10/25/2010
License Status:	REGULAR
Effective Date:	10/23/2021
Expiration Date:	10/22/2022
Capacity:	40
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A had a change of condition.	No
Resident A had not received his medications as prescribed.	Yes
Staff were not trained to care for residents with dementia.	No
Additional Findings	No

III. METHODOLOGY

04/19/2022	Special Investigation Intake 2022A1027051
04/19/2022	Special Investigation Initiated - Telephone Telephone interview conducted with complainant
04/26/2022	Inspection Completed On-site Interviews conducted with administrator Ms. McCullough-Benner and Employee #1. Documentation pertaining to Resident A will be emailed.
04/29/2022	Contact - Document Received Requested documentation received from administrator Ms. McCullough-Benner
05/13/2022	Contact - Document Sent Email sent to Ms. McCollough-Benner requesting additional information and documentation
05/13/2022	Contact - Document Received Requested documentation received from administrator Ms. McCullough-Benner
05/16/2022	Contact - Document Sent Email sent to Ms. McCollough-Benner requesting information/documentation
05/18/2022	Contact – Document Received Email received from Ms. McCollough-Benner with requested documentation

05/18/2022	Inspection Completed - BCAL Sub. Compliance
06/08/2022	Exit Conference Conducted by telephone with authorized representative Emery Dumas

ALLEGATION:

Resident A had a change of condition.

INVESTIGATION:

On 4/19/2022, the department received a complaint which read Resident A had not eaten or drank fluids in couple of days.

On 4/19/2022, I conducted a telephone interview with the complainant who stated Resident A had not eaten or drank fluids in a couple days prior to his hospitalization in February 2022. The complainant stated staff had not notified management of Resident A's change in condition which ultimately led to renal failure and subsequent demise in February 2022. Additionally, the complainant stated he had visited Resident A twice at the facility in which he found unchewed food in mouth.

On 4/26/2022, I conducted an on-site inspection at the facility. I interviewed administrator Laurie McCollough-Benner who stated she was not familiar with Resident A and had not been the facility's administrator at that time. Ms. McCollough-Benner stated the facility did not maintain intake records. I interviewed Employee #1 who stated she had started in her current position two weeks ago and was not familiar with Resident A.

I reviewed Resident A's face sheet which read he admitted to the facility on 12/7/2021.

I reviewed Resident A's diet order which read general diet, regular texture, thin consistency.

I reviewed Resident A's weight summary which read he weighed 172 lbs on 1/11/2022 and 2/7/2022.

I reviewed Resident A's progress notes which read he was evaluated by nurse practitioner Edward Matusik on the following dates 12/15/2022, 12/22/2022, 12/29/2022, 1/5/2022, 1/12/2022, 1/19/2022, 1/26/2022, 2/2/2022, and 2/9/2022. The note dated 2/2/2022 read staff requested Resident A be evaluated for lethargy, pain management review, and chronic condition management review. The note read Resident A's oral mucosa was pink and moist without ulceration. The note read neurological exam was alert and orientated to self, CN [central nerves] 2-12 grossly

intact, and cognitive impairment noted. The note read to continue current treatment/plan/diagnosis/medications. The note dated 2/9/2022 read staff requested Resident A be evaluated for increase in lethargy, hypertensive management review and chronic condition management review. The note read resident was seen sleeping with respirations unlabored and was able to be aroused with tactile stimulation. The note read Resident A's oral mucosa was pink and moist without ulceration. The note read under assessment and plan

2. Lethargy.
-Resident (A) recently received a change of medication; we will continue to monitor. Continue to be cautious in increase in psychoactive drugs secondary to oversedation.

Additionally, the note read to continue current treatment/plan/diagnosis/medications.

I reviewed Resident A's chart notes from December 2021 through February 2022. Chart notes dated 1/30/2022, 2/2/2022, 2/5/2022, 2/6/2022, 2/7/2022, and 2/9/2022 which were written by the facility's registered nurse or licensed practical nurses read Resident A had episodes of lethargy.

Chart note dated 2/5/2022 read

Resident very sleepy, required two staff to transfer resident from his bed to a wheel chair and take him to dining room table. Staff had to feed him soft liquid type food since he did not have his teeth in. Jell-O, applesauce, and ice cream. Drinking water with assistance as he is unable to hold the cup to his lips to drink. Taking nourishment with his eyes closed. Has harsh cough at times but staff monitoring him while they are feeding him. Continue to monitor.

Chart note dated 2/6/2022 in part read

I was able to get apple sauce, some jello and a glass of water in to [sp] him. Resident then refused any other nutrition, refused to open mouth.

I reviewed the resident census for 1/30/2022 through 2/9/2022 which corresponded to the facility's meal census for those dates.

I reviewed the facility's *Change of Condition and Physician Notification* policy. The policy read in part staff were to contact a resident's physician for physical symptoms

Level of Consciousness:
-Going from alert to lethargic
-Going form [sp] lethargic to stuperous
-Onset of hostile or combative behavior
-Non-responsiveness

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
ANALYSIS:	Although facility chart notes revealed Resident A had episodes of lethargy, Resident's A health care professional notes revealed staff had requested evaluations for his condition. Review of health care professional progress notes from 2/2/2022 and 2/9/2022 read Resident A was examined by the nurse practitioner and there were no treatment plan or medication changes. Review of meal records revealed meals were provided from 1/30/2022 through 2/9/2022.There was insufficient evidence to support this allegation.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A had not received his medications as prescribed.

INVESTIGATION:

On 4/19/2022, the department received a complaint which read Resident A had not received his medications as scheduled and was over medicated.

On 4/19/2022, I conducted a telephone interview with the complainant. The complainant stated he met with the facility's previous director of nursing on 2/9/2022 in which he was informed by her that Resident A had not been administered his medications appropriately. The complainant stated Resident A's Klonopin and Seroquel were supposed to be given at staggering times, however the facility administered them at the same time. Additionally, the complainant stated Resident A received his medications in applesauce.

On 4/26/2022, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated the facility would need a physician order to administer medications crushed in applesauce, but not whole in applesauce.

I reviewed Resident A's progress notes which read he was evaluated by nurse practitioner Edward Matusik. Progress note dated 1/12/2022 read to initiate Klonopin twice daily as needed. Progress note dated 1/19/2022 read medications appear to be ineffective and plan to trial Seroquel, as well as Risperdol. Progress note dated 1/26/2022 read Resident A was currently on Seroquel, Risperdal, and Klonopin in which his medication regimen appeared to be more effective at that time. Progress note dated 2/2/2022 read continue with current doses of Seroquel and Klonopin. Progress note dated 2/9/2022 read Resident A recently had medication adjustments with Klonopin and Seroquel. Additionally, the note read continue to be cautious in increase in psychoactive drugs secondary to oversedation.

I reviewed Resident A's medication administration records (MAR) for January and February 2022.

The January 2022 MAR read

-Klonopin tablet 0.5 mg (clonazepam), give 0.5 mg by mouth every 12 hours as needed for anxiety for 14 days. Start date 1/10/2022 through 1/24/2022.

-Clonazepam tablet 0.5 mg, give 1 tablet by mouth two times a day for anxiety. Start date 1/26/2022. Discontinue date 2/3/2022.

-Seroquel tablet 50 mg (quetiapine fumarate), give 50 mg by mouth one time for anxiety. Start date 1/11/2022. Discontinue date 1/11/2022.

-Seroquel tablet 50 mg (quetiapine fumarate), give 50 mg by mouth in the evening for anxiety. Start date 1/12/2022. Discontinue date 1/19/2022.

-Seroquel tablet 50 mg (quetiapine fumarate), give 50 mg by mouth every morning and at bedtime for anxiety. Start date 1/19/2022. Discontinue date 2/3/2022.

The February 2022 MAR read

-Clonazepam tablet 0.5 mg, give 1 tablet by mouth two times a day for anxiety. Start date 1/26/2022. Discontinue date 2/3/2022.

-Klonopin tablet 0.5 mg (Clonazepam), give 1 tablet by mouth two times a day for anxiety. Start date 2/3/2022. Discontinue date 2/7/2022.

-Seroquel tablet 50 mg (quetiapine fumarate), give 50 mg by mouth every morning and at bedtime for anxiety. Start date 1/19/2022. Discontinue date 2/3/2022.

-Seroquel tablet 50 mg (quetiapine fumarate), give 50 mg by mouth two times a day for anxiety. Start date 2/3/2022. Discontinue date 2/7/2022.

-Seroquel tablet 50 mg (quetiapine fumarate), give 50 mg by mouth two times a day for anxiety. Start date 2/7/2022. Discontinue date 4/25/2022.

Additionally, the February 2022 MAR read on 2/2/2022 the following medications were left blank and not marked as administered B Complex B-12 tablet, Clonazepam 2100 [9:00 PM] dose, Enalapril Maleate, Risperidone, the bedtime dose of Seroquel, and Vitamin D3.

I reviewed Resident A's physician order summary report, which included medication orders for Seroquel and Klonopin, and read consistent with the MARs reviewed.

I reviewed Resident A's chart notes from December 2021 through February 2022 which read consistent with his MARs.

APPLICABLE RULE	
R 325.1932	**Resident medications.**
	(1) Medication shall be given, taken, or applied pursuant to labeling instructions or orders by the prescribing licensed health care professional.
ANALYSIS:	Although review of facility documentation revealed Resident A's Klonopin and Seroquel were given as ordered by his licensed health care professional, the MAR read some medications were left blank and not initialed as administered. The facility staff did not mark a reason for the missed doses; therefore, it cannot be confirmed why the medication administration was not completed as scheduled. Based on this information, this allegation was substantiated.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff were not trained to care for residents with dementia.

INVESTIGATION:

On 4/19/2022, the department received a complaint which alleged staff lacked qualifications to care for individuals with dementia.

On 4/19/2022, I conducted a telephone interview with the complainant who stated he was concerned staff were not trained appropriately to care for residents with

dementia. The complainant stated there was one staff member who cared for the memory care residents very well, however he was concerned regarding the others.

On 4/26/2022, I conducted an on-site inspection at the facility. I interviewed administrator Laurie McCollough-Benner who stated all care staff receive dementia training in their orientation since assisted living residents may also have a dementia diagnosis. I interviewed Employee #1 who stated there was a dementia training binder in which staff who were consistently providing care in the memory care unit would receive additional training. While on-site, I reviewed the dementia training binder which included the following topics defining dementia and Alzheimer's disease, understanding the stages and behaviors, understanding current medications and treatments, understanding person centered care, strategies for implementing care, verbal and non-verbal communication, techniques for providing meaningful communication with persons with dementia, understand the correct use of validation and reality orientation, understand how and why behaviors become challenging, ways to prevent behaviors, responding to challenging behaviors, emotions of persons with dementia, causes of resistance to Activities of Daily Living (ADL), promoting participation in personal care, managing ADLs, and signs of abuse and neglect, as well as education pertaining to families with persons diagnosed with dementia.

I reviewed an employee list for those who worked in the memory care unit from 1/23/2022 through 2/12/2022. The list read there were 15 staff consisting of resident care associates, medication technicians, and licensed practical nurses in which nine were primary staff and the six staff were fill-ins.

I reviewed staff training titled *High Risk Diagnosis: Dementia* provided in staff's general orientation which read instructions on communication: listening and speaking, communication strategies, communication: things to avoid, and understanding behaviors.

I reviewed random a sample of employee training records who were assigned to the memory care unit from 1/23/2022 through 2/12/2022. Employee #2, Employee #3, Employee #4, and Employee #5's *Relias* course transcripts read they had received dementia training in which the courses were titled: *Caring for the Person with Dementia: Behaviors and Communication*, *Dementia Care: Coaching and Completing Activities of Daily Living*, *Dementia Care: Managing Challenging Behaviors*, and *Dementia Care: Preventing Catastrophic Reactions*. Additionally, the employee's transcripts read they had received some trainings yearly and passed an examination each time.

APPLICABLE RULE	
333.20178	**Nursing home, home for the aged, or county medical care facility; description of services to patients or residents with Alzheimer's disease; contents; "represents to the public" defined.**
	Sec. 20178. (1) Beginning not more than 90 days after the effective date of the amendatory act that added this section, a health facility or agency that is a nursing home, home for the aged, or county medical care facility that represents to the public that it provides inpatient care or services or residential care or services, or both, to persons with Alzheimer's disease or a related condition shall provide to each prospective patient, resident, or surrogate decision maker a written description of the services provided by the health facility or agency to patients or residents with Alzheimer's disease or a related condition. A written description shall include, but not be limited to, all of the following: **(d) Staff training and continuing education practices.**
ANALYSIS:	Review of the facility's dementia training program, as well as review of a random sample of staff training records revealed the facility provided staff training for dementia as well as continued to educate staff using their *Relias* program. Based on this information, the facility complies with this rule and this allegation cannot be substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

On 6/8/2022, I shared the findings of this report with authorized representative Emery Dumas by telephone. Mr. Dumas verbalized understanding of the findings.

IV. RECOMMENDATION

Contingent upon receipt of an acceptable corrective action plan, I recommend the status of the license remain unchanged.

5/17/2022

Jessica Rogers Date
Licensing Staff

Approved By:

06/08/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section