GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 21, 2025

Michael Wernette
Mission Point Health Campus of Jackson
703 Robinson Rd.
Jackson, MI 49203-2538

RE: License #: AH380301277
Investigation #: 2025A1019038

Dear Licensee:

Attached is the Special Investigation Report for the above-mentioned 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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

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) 284-9730.

Sincerely,

Elizabeth Gregory-Weil, Licensing Staff
Bureau of Community and Health Systems
611 W. Ottawa Street
P.O. Box 30664
Lansing, MI 48909
(810) 347-5503

enclosure

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

I. IDENTIFYING INFORMATION

License #:	AH380301277
Investigation #:	2025A1019038
Complaint Receipt Date:	02/26/2025
Investigation Initiation Date:	02/27/2025
Report Due Date:	04/28/2025
Licensee Name:	Mission Point Health Campus of Jackson, LLC
Licensee Address:	30700 Telegraph Road Bingham Farms, MI 48205
Licensee Telephone #:	(502) 213-1710
Administrator:	Cindy Goodrich
Authorized Representative:	Michael Wernette
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:	10/23/2024
Expiration Date:	07/31/2025
Capacity:	40
Program Type:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A has been neglected.	No
Resident A may not have received medical care when needed.	No
Additional Findings	Yes

III. METHODOLOGY

02/26/2025	Special Investigation Intake 2025A1019038
02/26/2025	Comment Complaint was forwarded to LARA from APS. APS denied the referral and is not investigating.
02/27/2025	Special Investigation Initiated Licensing staff J. Rogers contacted the facility to verify if the named resident resides in the HFA or the skilled nursing area of the building. Per Ms. Rogers, it was confirmed to be an HFA resident.
03/05/2025	Inspection Completed On-site
03/18/2025	Inspection Completed BCAL Sub. Compliance

ALLEGATION:

Resident A has been neglected

INVESTIGATION:

On 2/26/25, the department received a complaint alleging that Resident A has been neglected by facility staff. The complaint alleged that on 2/23/25, Resident A was sent to the hospital and was observed to have dried food all over him, he appeared to not have been bathed in a while, was not properly dressed and had not been out of bed in three days. The complainant reported that she was told this information by another person and did not directly observe the allegations. Due to the anonymous nature of the complaint, additional information could not be obtained.

On 3/5/25, I conducted an onsite inspection. I interviewed Employee 1. Employee 1 reported that Resident A has been hospitalized several times recently due to having low O2 levels. Employee 1 reported that Resident A is a PACE participant and PACE is involved in his medical treatment and overall coordination of care. Employee 1 reported that Resident A has recently experienced a decline in baseline level of functioning, including decreased mobility, increased confusion and delusions and being combative at times with care and towards others. Employee 1 confirmed that Resident A was taken to the hospital on 2/23/25 because they could not stabilize his oxygen levels. Employee 1 provided a progress note on the event that read:

> *This nurse was asked by RA to assist this resident. Upon arrival to resident's room I found that resident has been combative and confused all day per [Med tech]. resident had pulled out his catheter, was throwing food, refusing to keep his nasal cannula on and attempting to strike staff all shift. Resident was not wearing any O2 at all upon my arrival as he had chewed through the O2 tubing. I turned residents O2 concentrator all the way up and placed a non-rebreather mask, that was at bedside, over resident's nose and mouth. Resident's O2 concentration at this time was reading 60%. Med tech reported that resident recently had pneumonia and is full code status. I instructed [med tech] to call 911 as resident's oxygen concentration was only in the 70% range after several minutes on nonrebreather. Paramedics arrived and transported resident to hospital for further evaluation.*

Employee 1 reported that Resident A returned to the facility from the hospital on the same day with a UTI diagnosis. Employee 1 reported that resident laundry is completed daily, that staff get Resident A up every day, as he attends the PACE program five days per week, and complete checks on him every two hours. Employee 1 reported that Resident A is independent with feeding but lately is being served meal trays in his room. Employee 1 reported that Resident A is scheduled to receive two showers weekly and that staff are expected to document bathing activities electronically and should complete a skin assessment once a week during bathing. While onsite, Employee 1 could not locate the electronic bathing records for Resident A but provided the skin assessment forms that revealed bathing activities occurred on the following days in February 2025: 2/13/25 and 2/26/25. In follow up correspondence, Employee 1 provided additional documentation that staff are to complete daily outlining care that each resident receives per shift. The "care sheet" documentation revealed bathing activities on the following days in February 2025: 2/13/25, 2/16/25, 2/18/25, 2/20/25 and 2/26/25. Review of additional documentation reveal that Resident A was hospitalized on the following dates during February 2025: 2/2/25-2/10/25, 2/12/25 (partial day), 2/23/25 (returned same day) and again on 2/24/25.

Employee 1 reported that at the time of Resident A's hospitalization on 2/23/25, Employees 2 and 3 worked directly with him. A statement from Employee 2 read:

Sunday February 23rd during day shift [Resident A] was having unexpected behaviors. [Resident A] started by pulling his catheter out and I called pace to informed them and to have someone come out and replace it. A nurse from pace came and replaced his catheter, [Resident A] then started to take his oxygen off every chance he could. When staff informed [Resident A] that he needs to keep his oxygen on he was not to [sic] fond about it. he eventually chewed through his oxygen cord and staff replaced it with a new one. Then [Resident A] decided he didn't want his lunch and threw his tray in his room. Staff cleaned the mess and put the tray on the cart. Staff asked [Resident A] if he needed a new brief and he said no. when staff went back to his room he threw his wet brief on the floor. Staff grabbed a new brief and tried to assist him but he was trying to hit staff. Staff left the room and came back to get a new brief on his and he was still refusing. [Resident A's] oxygen was eventually dropping due to not keeping nasal oxygen on. [Employee 4] assisted with [Resident A's] oxygen but it was still dropping. Staff contacted pace and pace said to call for an ambulance. Staff informed DON and resident's family. [Resident A] was then sent to the hospital due to oxygen dropping.

A statement from Employee 4 read:

On February 23rd resident combative when I was trying to get his washed and changed. He was trying to kick us & grab us. I tried a couple times to do cares but he was angry. He threw his food tray at us. The med tech wasn't able to calm him down and had to get the nurse from the rehab unit. Then he was sent to the hospital because his oxygen got low & wouldn't come back up. He was very confused.

APPLICABLE RULE	
R 325.1933	**Personal care of residents.**
	(1) A home shall provide a resident with necessary assistance with personal care such as, but not limited to, care of the skin, mouth and teeth, hands and feet, and the shampooing and grooming of the hair as specified in the resident's service plan. **(2) A home shall afford a resident the opportunity and instructions when necessary for daily bathing, oral and personal hygiene, daily shaving, and hand washing before meals. A home shall ensure that a resident bathes at least weekly and more often if necessary.**

ANALYSIS:	Attestations from staff reveal that on 2/23/25, Resident A was experiencing a behavioral outburst including removing his catheter, refusing to wear his oxygen, throwing his food and removing his brief prior to being sent out to the hospital. These behaviors prohibited staff from completing routine care that he required. Despite this, documentation provided by the facility reveal that he was bathed at least weekly during the timeframe reviewed, which was outside of the documented dates he was hospitalized.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ALLEGATION:

Resident A may not have received medical care when needed.

INVESTIGATION:

The complaint read that about three weeks to a month prior to the complaint date, Resident A broke his femur (exact date not provided) and was concerned that he was not medically evaluated for this injury. Employee 1 confirmed that on 2/2/25, Resident A had a fall and was taken to the hospital where he subsequently had surgery. Employee 1 reported that at the time the fall occurred, Resident A ambulated independently with the use of a cane. Employee 1 reported that staff observed Resident A on the floor and contacted EMS to have him taken to the hospital the same day. Employee 1 provided documentation including an incident report and paperwork from Resident A's hospitalization from the incident.

The incident report dated 2/2/25 read:

> *At approximately 0820 resident was observed on the floor in front of his recliner in his room. Resident stated he was walking to his recliner to sit down. Resident stated he did not hit his head, but his right arm, leg and knee hurt. Resident has an abrasion on his right knee. Med tech cleaned with normal saline and gauze and placed band aides on the abrasion. ROM completed and vitals were taken…Thome pace on call nurse notified and EMS was dispatched by Thome pace nurse to send resident to hospital for evaluation and treatment. [Daughter] and DON notified. Resident stated he was walking to sit in his recliner and he does not know what happened after that.*

The discharge summary from Henry Ford Jackson Hospital read that Resident A was hospitalized from 2/2/25-2/10/25. Resident A's injuries were documented as "*right impacted subcapital femur fracture*", "*subtle right anterior wall acetabulum fracture*" and "*right 8th rib fracture*" and outlined that Resident A had orthopedic surgery on 2/5/25.

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: **(c) Assure the availability of emergency medical care required by a resident.**
ANALYSIS:	Resident A had a fall with injury on 2/2/25. An incident report and documentation from Henry Ford Hospital demonstrate that Resident A was medically evaluated the same day as the incident occurred.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

ADDITIONAL FINDINGS:

INVESTIGATION:

Per Employee 1, Resident A (and all residents) is to receive two showers weekly. Employee 1 reported that Resident A's assigned shower days are Wednesday and Sunday, but that can change depending on staffing and if Resident A refuses. Regarding bathing, Resident A's service plan read:

> *Be gentle washing [Resident A's] skin and pat dry with towel do not rub.*
>
> *Encourage [Resident A] to participate as much as possible.*
>
> *[Resident A] requires assistance of one care team member for all aspect [sic] of bathing, transferring, washing, drying, dressing.*
>
> *[Resident A] requires set up: laying out towel, preparing bathmat on floor, preparing water temperature, etc.*

The service plan did not mention the frequency at which Resident A should bathe and did not indicate he should get two showers per week as Employee 1 attested to.

APPLICABLE RULE	
R 325.1922	**Employees; general provisions.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the

	resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.
For Reference: R 325.1901	**Definitions.**
	(t) "Service plan" means a written statement prepared by the home in cooperation with a resident, the resident's authorized representative, or the agency responsible for a resident's placement, if any, that identifies the specific care and maintenance, services, and resident activities appropriate for the individual resident's physical, social, and behavioral needs and well-being, and the methods of providing the care and services while taking into account the preferences and competency of the resident.
ANALYSIS:	Resident A's service plan was not updated to include his frequency of bathing activities.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

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

03/18/2025

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Elizabeth Gregory-Weil Date
Licensing Staff

Approved By:

03/21/2025

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