GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

March 13, 2024

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

RE: License #: AH380301277
Investigation #: 2024A1027029
Mission Point Health Campus of Jackson

Dear Licensee:

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.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the authorized representative and a date.

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. Failure to submit an acceptable corrective action plan will result in disciplinary action.
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 877-458-2757.

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 #:	2024A1027029
Complaint Receipt Date:	01/30/2024
Investigation Initiation Date:	01/30/2024
Report Due Date:	03/29/2024
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 Stacks
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:	10/23/2023
Expiration Date:	10/22/2024
Capacity:	40
Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A lacked care.	Yes
Staff have their children at work.	No
Additional Findings	No

III. METHODOLOGY

01/30/2024	Special Investigation Intake 2024A1027029
01/30/2024	Special Investigation Initiated - Telephone Complainant interviewed by telephone, and additional information was received.
02/08/2024	Inspection Completed On-site
02/12/2024	Contact - Document Received Email received from Employee #1 with Resident A's admission contract
02/21/2024	Inspection Completed-BCAL Sub. Compliance
03/13/2024	Exit Conference Conducted by email with Michael Stacks and Cindy Goodrich

ALLEGATION:

Resident A lacked care.

INVESTIGATION:

On 1/30/2024, the Department received a complaint through the online complaint system which read no staff assisted Resident A while she was at the facility for three days The complaint read it would take 2-3 hours before a staff member to come to her room. The complaint read an ambulance was called to take her to the hospital for assistance on 1/11/2024. The complaint read in the emergency room "*she was so bad that they could not even get her triaged until they got her cleaned up*." The complaint read Resident A had fluid buildup, was admitted to the hospital, then passed away on 1/20/2024.

On 1/30/2024, I conducted a telephone interview with complainant in which her statements were consistent with complaint. The complainant stated Resident A resided at the facility's skilled nursing rehabilitation center for approximately two weeks; however, her insurance would no longer cover her therapy services, so she was transitioned to assisted living. The complainant stated it was planned for Resident A to have physical therapy through a home care agency while at the assisted living; however, she went to the emergency room for treatment prior to starting those services.

The complainant stated Resident A was totally dependent for care and had a pressure sore on her side from staying on one side. The complainant stated the director of nursing stated she did not know why Resident A was admitted to the assisted living.

On 2/8/2024, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated Resident A transferred from skilled nursing to the Homes for the Aged because she could not return home; however, she was only there for 1-2 days. Employee #1 stated staff transferred Resident A from the bed to the recliner chair with an EZ stand lift, which required two-person assistance. Employee #1 stated Resident A declined to transfer out of the recliner chair and refused care. Employee #1 stated the computer system was down from 1/9/2024 to 1/11/2024 so there was lack of documentation for Resident A. Employee #1 stated she had not completed a service plan for Resident A yet. Additionally, Employee #1 stated she attempted to obtain a bariatric bed for Resident A, but she did not qualify for it.

Employee #1 stated the resident census in the assisted living at the time Resident A's admission was 21 residents in which most were "*fairly independent*." Employee #1 stated the staffing schedule including three shifts. Employee #1 stated on day and afternoon shifts there were two resident care assistants and one medication technician scheduled. Employee #1 stated on night shift there was one resident care assistant and one medication technician scheduled.

While on-site, I interviewed Resident B regarding the care at the facility. Resident B stated she was mostly independent with her activities of daily living. Resident B stated some days staff were good in providing all her services, and some days staff were not. Resident B stated she was supposed to receive fresh water in a Styrofoam cup with a lid everyday but had not received water since Tuesday. Resident B stated she was supposed to have her bed made every day; however, it was not made. Resident B state she would often have to ask for the services she was supposed to receive. Resident B stated staff responded to the call light timely most of the time.

While on-site, I observed Resident B's apartment in which her bed was not made. I observed Resident B had one small clear plastic glass of water on sink in which she stated she filled up one of her previous juice cups with sink water.

While on-site, I interviewed Employee #2 who stated residents received a water in Styrofoam cup with a lid every shift, so they should receive three waters per day.

I reviewed Resident A's face sheet which read in part her admission date was 1/9/2024.

I reviewed Resident A's physician note dated 1/5/2024 which read in part she had a primary medical history of diabetes mellitus type II, hypertension, cirrhosis of the liver, and was recently treated for an upper gastrointestinal bleed. The note read in part Resident A transferred to the skilled facility for subacute rehabilitation and continuation of care. The note read in part Resident A had a prolonged hospitalization and now severe deconditioning. The note read in part Resident A was cooperative with his exam, as well as "*alert and orientated x3*." The note read in part Resident A's insurance was contacted to facilitate further time with therapy.

I reviewed Resident A's service plan dated 12/22/2023 which read in part the registered nurse, licensed practical nurse, certified nursing assistant, dietitian, social worker, and/or recreational director were to complete her interventions or tasks. The plan read in part it was created by the skilled facility registered nurse and revised by a skilled facility registered nurse. The plan read in part Resident A was at risk for impaired skin integrity related to decreased mobility. The plan read in part Resident A had three open areas on her coccyx and two open areas on her right abdomen. The plan read in part Resident A was two-person assist with an EZ stand. The plan read in part Resident A was at the facility for a short term stay for gastrointestinal hemorrhage with potential difficulty with strength, endurance, bed mobility, transfers, standing or walking.

I reviewed Resident A's physician orders which read consistent with her face sheet. The orders read in part Resident A was prescribed a consistent carbohydrate diet, full resuscitation, and her list of medications which included but was not limited to Lasix for edema and nystatin powder for fungal rash under her left abdominal fold.

I reviewed Resident B's service plan which read consistent with her statements. The plan read in part to encourage her to drink adequate amounts of fluids throughout the day and with meals. The plan read in part to make her bed daily.

APPLICABLE RULE	
R 325.1931	**Employees; general provisions.**
	(2) A home shall treat a resident with dignity and his or her personal needs, including protection and safety, shall be attended to consistent with the resident's service plan.
For Reference: R 325.1901	**Definitions.**

	Rule 1. As used in these rules:
	(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:	Review of Resident A's medical records read consistent with the complainant's interview. Interview with Employee #1 revealed the facility lacked records through their charting system of Resident A's care due to a computer system issue. Nonetheless, the service plan read consistent with care provided in the skilled nursing facility and was not updated nor reflective of the care required in the Homes for the Aged. Additionally, Resident B was randomly chosen to be interviewed in which her attestations and observations revealed her care was not consistent with her service plan. Therefore, it can be concluded that Resident A was not provided care consistent with her service plan since the plan was not updated or revised to reflect her needs in the Homes for the Aged. Additionally Resident B's care was not consistent with her service plan, thus there was violation for this allegation.
CONCLUSION:	**VIOLATION ESTABLISHED**

ALLEGATION:

Staff have their children at work.

INVESTIGATION:

On 1/30/2024, the Department received a complaint which read the nursing staff have their children at work with them.

On 1/30/2024, I conducted a telephone interview with the complainant who stated on 1/11/2024 when her son picked up some of Resident A's belongings from the facility and a staff member had their child at work.

The complainant stated she picked up Resident A's medical records on 1/23/2024 and a staff member in medical records had her baby at work with her.

On 2/8/2024, I conducted an on-site inspection at the facility. I interviewed Employee #1 who stated there was no policy in the employee handbook regarding staff bringing their children to work for a short period of time; however, the child or children must be of school age and stay in the common area next to the nurses' station. Employee #1 stated there was a television, couch, and puzzles in the common area for use by residents and visitors. Employee #1 stated there was one employee recently who had difficulty with her child's day care after school in which the school aged child would stay from 3:00 PM to 5:00 PM until the father could pick her up; however, the employee no longer had difficulty with childcare arrangements, and the child no longer comes to the facility. Employee #1 stated the medical records department staff were not part of the Homes for the Aged.

While onsite, I interviewed administrator Cindy Goodrich whose statements were consistent with Employee #1. Ms. Goodrich stated the residents enjoyed seeing the children in the facility. Ms. Goodrich stated there were social activities that included visits from visitors' or employees' children.

While on-site, I did not observe a child or children in the common area nor in the Homes for the Aged part of the facility. I observed the common area which was consistent with statements from Employee #1 and included a table with chairs.

While on-site, I interviewed Resident B who stated she had observed children in the facility visiting with the other residents and she enjoyed seeing them.

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:	Staff attestations revealed there was not a facility policy in place regarding staff bringing a school aged child to work for a short period of time. Staff attestations also revealed the medical records staff were not part of the licensed Home for the Aged; therefore, this allegation was not substantiated.
CONCLUSION:	**VIOLATION NOT ESTABLISHED**

IV. RECOMMENDATION

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

02/21/2024

Jessica Rogers Date
Licensing Staff

Approved By:

03/11/2024

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