GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

August 05, 2024

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

RE: License #: AH380301277
Investigation #: 2024A1027077
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 #:	2024A1027077
Complaint Receipt Date:	07/03/2024
Investigation Initiation Date:	07/03/2024
Report Due Date:	09/02/2024
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:	ALZHEIMERS AGED

II. ALLEGATION(S)

	Violation Established?
Resident A was neglected.	Yes
Additional Findings	No

III. METHODOLOGY

07/03/2024	Special Investigation Intake 2024A1027077
07/03/2024	Special Investigation Initiated - Letter Email sent to Cindy Goodrich and Michael Stacks requesting documentation pertaining to Resident
07/05/2024	Contact - Document Received Email received from Ms. Goodrich with requested documentation
07/18/2024	Inspection Completed On-site
07/18/2024	Inspection Completed-BCAL Sub. Compliance
08/05/2024	Exit Conference Conducted by email with Cindy Goodrich and Michael Stacks

ALLEGATION:

Resident A was neglected.

INVESTIGATION:

On 7/3/2024, the Department received allegations forwarded from Adult Protective Services (APS) which read Resident A's briefs unchanged, and staff did not take him out of his room. The complaint alleged Resident A had bed sores and staff do not change his position frequently. Additionally, it mentioned that staff changed Resident A 1-2 times per day.

On 7/18/2024, an on-site inspection was conducted, and staff were interviewed.

Administrator Cindy Goodrich described Resident A as "*non-compliant*" and intermittently refused care.

Employee #1's statements corroborated with Ms. Goodrich. Employee #1 explained that Resident was initially admitted to the skilled nursing facility on campus, then subsequently transitioned back and forth between both facilities twice. Employee #1 stated staff checked and changed Resident A every two hours; however, he did not always alert staff when he was soiled between checks. Employee #1 added that Resident A, though capable of walking with a walker to the toilet, often preferred to remain in bed. Employee #1 stated Resident A's buttock area was excoriated and staff applied barrier cream, as well as his wedge for positioning if he permitted. Employee #1 stated Resident A received Henry Ford Home Care services for wound care and therapy. Employee #1 stated Resident A declined to pay for his briefs and exhausted the donated supply of briefs in the facility; however, his daughter provided briefs for him recently.

During the inspection, Resident A's service plan was reviewed, revealing scheduled shower days were on Sundays and Wednesdays. Shower records from 6/12/2024, and 7/6/2024, and an undated sheet indicated wounds on Resident A's legs and buttocks were noted during completed showers.

Employee #1 stated staff completed shower sheets for each resident; however, were required to only document the first shower of the week.

Employee #2's statements corroborated those of Ms. Goodrich and Employee #1, noting Resident A's intermittent refusal of showers, including the previous day.

Review of Resident A's face sheet read in part he moved into the facility on 6/3/2024, with himself listed as the emergency contact.

Review of Resident A's service plan updated on 7/5/2024 read in part Resident A preferred not to shower or bathe and included reminders for staff to prompt him to use the toilet to prevent soiling affecting his wounds. It reiterated the presence of Henry Ford Home Care services visiting on Monday and Thursday mornings and noted Resident A's preference for activities in his room and his bed for comfort.

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.

ANALYSIS:	The complaint initially claimed that Resident A's briefs were not changed, but later indicated they were changed 1-2 times per day. Nevertheless, a review of Resident A's records revealed he required assistance with his activities of daily living. Furthermore, the complaint alleged Resident A was not taken out of his room; however, his service plan indicated a preference to stay in his room. Additionally, staff statements and Resident A's service plan indicated he declined assistance and care intermittently. However, review of his shower logs revealed insufficient documentation to confirm that showers were provided in accordance with his service plan. While the allegations in the complaint could not be confirmed, a violation was substantiated regarding lack of care consistent with his service plan.
CONCLUSION:	**REPEAT VIOLATION ESTABLISHED** **[For reference, see special investigation report (SIR) 2024A1027029 dated 3/13/2024, CAP dated 3/28/2024]**

IV. RECOMMENDATION

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

07/18/2024

Jessica Rogers Date
Licensing Staff

Approved By:

08/05/2024

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