

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235187	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2025
NAME OF PROVIDER OR SUPPLIER Mission Point Nsg Phy Rehab Ctr of Madison Heights		STREET ADDRESS, CITY, STATE, ZIP CODE 31155 Dequindre Madison Heights, MI 48071	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>30675</p> <p>Based on observation and interview the facility failed to ensure light cords were maintained at an appropriate length that was within reach for five (R12, R26, R55, R66, and R78) of five residents reviewed for accommodation of needs.</p> <p>Findings include:</p> <p>Observations conducted from 1/7/25 to 1/8/25 on the facility's 2 East unit revealed the rooms occupied by R12, R26, R55, R66, and R78 were all observed to have lights above their bed with metal pull strings to turn on/off the lights that were only a few inches in length, and unable to be accessed within reach to use.</p> <p>On 1/8/25 at 2:325 PM, during observations of 2 East with the Plant Operations Manager/Maintenance Director (Staff 'F') and the Housekeeping/Laundry Supervisor (Staff 'E'), the same observations were made of the light pull strings. When asked if that had been identified on any audits, or maintenance logs, Staff 'E' reported there were many residents on 2 East unit that had behaviors of pulling things off the walls, including the light cords and they were not aware of any specifically for these rooms.</p> <p>On 1/9/25 at 11:19 AM, the facility was requested to provide any invoices for furniture/room/equipment repairs. There was no further documentation provided for review by the end of the survey.</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>30675</p> <p>Based on interview and record review the facility failed to ensure the residents' right to receive unopened and private mail delivery was maintained for two of eight residents that attended the confidential resident group interview.</p> <p>Findings include:</p> <p>On 1/7/25 at 11:40 AM, a confidential resident group interview was conducted with eight residents. When asked if they received their personal mail on time and unopened, two residents reported the following concerns:</p> <p>One resident reported they received several Christmas cards from family members from out of state that were opened when delivered to them.</p> <p>Another resident reported they were frustrated they had to ask for their mail at times and frustrated because their packages that get delivered were delayed at times since it goes to the receptionist, then activities staff, and sometimes gets mixed up with the maintenance staff's things and takes days to get to them. They further reported they were told the staff have to watch me open my packages to make sure there wasn't anything in it that shouldn't be. The resident reported they felt this was against their rights as a resident, against federal law, and also may have some sensitive/personal items they didn't feel the staff needed to see or know about.</p> <p>On 1/8/24 at 3:50 PM, an interview was conducted with the Administrator. When asked about the facility's process for mail delivery, the Administrator reported the mail was coordinated by their activity staff. They further reported once it was received by the receptionist, the activity staff delivered it directly to the residents. When asked if mail was ever opened or if residents were made to open packages in front of staff, the Administrator reported they hadn't heard of that but staff could assist with opening packages if the residents requested. The Administrator was informed of the concerns brought up in resident council of activity staff telling residents the packages needed to be opened upon delivery so they could verify the contents and the Administrator reported some residents had concerns with ordering of medications and vapes but if they didn't want help with opening packages, then that should be followed. They were informed of the specific details reported regarding resident rights and mail and indicated they would have to follow-up.</p> <p>On 1/9/24 at 8:55 AM, an interview was conducted with the Activity Director (Staff 'D'). When asked about the process for delivering residents' mail and packages, Staff 'D' reported they had spoken to the Administrator yesterday, following the concerns discussed during survey and spoke to residents with the concerns and informed they no longer needed to have packages opened in front of them. When asked why the facility had been doing that before the concern was brought up, Staff 'D' reported when they had started working at the facility (in 2024), the process was to have packages opened with residents because sometimes they or families would order medications and vapes and were now clear that could not be done.</p> <p>According to the facility's policy titled, Resident Rights dated 2/2024:</p> <p>(continued on next page)</p>		

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<p>F 0576</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility .The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service including the right to: i. Privacy of such communications consistent with this section .The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely .</p> <p>According to the facility's policy titled, Mail dated December 2006:</p> <p>.Residents are allowed to communicate privately with individuals of their choice and may send and receive their personal mail unopened unless otherwise advised by the Attending Physician and documented in the residents' medical records .Mail will be delivered to the resident unopened unless otherwise indicated by the Attending Physician and documented in the resident's medical record .Staff members of this facility will not open mail for the resident unless the resident requests them to do so. Such request will be documented in the chart .Mail will be delivered to the resident within twenty-four (24) hours of delivery on premises . Activities and/or Social Services Personnel will help residents obtain stationery, postage, and writing implements .</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415</p> <p>Based on observation, interview, and record reviews the facility failed to educate and offer to formulate an advance directive for one (R28) of six residents reviewed for the advance directives. Findings include:</p> <p>On 1/7/25 at 9:32 AM, R28 was observed in their room listening to music. R28 refused an interview at that time.</p> <p>A review of the medical record revealed R28 was admitted to the facility on [DATE] with diagnosis that included: bipolar disorder and depression.</p> <p>Review of the medical record revealed no documents or documentation of the facility to have educated and offer R28 to formulate an advance directive.</p> <p>A review of a facility policy titled Residents' Rights Regarding Treatment and Advance Directives dated 4/24, documented in part . It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive . On admission, the facility will determine if the resident has executed an advance directive . and if not, determine whether the resident would like to formulate an advance directive . The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive .</p> <p>On 1/8/25 at 12:19 PM, the Social Services Manager (SSM) H was interviewed and asked the facility's process in educating and offering the residents and/or resident representatives to formulate an advance directive. SSM H explained their department was responsible for obtaining the code status and had nothing to do with the education or offering to formulate an advance directive.</p> <p>On 1/9/25 at 9:34 AM, an interview was conducted with the Acting Administrator (AA) K (who filled in for the Administrator on the last day of survey) was interviewed and asked the facility's process in educating and offering residents and/or resident representatives to formulate an advance directive. AA K stated they would look into it and follow back up. At 1:35 PM, a follow up interview was conducted with AA K who stated the facility's social services department was responsible for the education and offering to formulate an advance directive to residents and/or resident representatives. AA K stated SSM H has been educated.</p> <p>No further explanation or documentation was provided by the end of the survey.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>Based on observation, interview and record review, the facility failed to maintain a safe, clean, comfortable and homelike environment, affecting multiple residents throughout the facility, including R3, R12, R22, R26, R30, R46, R55, and R32.</p> <p>Findings include:</p> <p>Observations of the facility's 2 East unit from 1/7/25 - 1/8/25 included:</p> <p>On 1/7/25 at 10:15 AM, the 2 East shower room revealed upon entry, stagnant, strong foul odors. There was a build-up of dark brownish colored substance along the perimeter of the shower walls and flooring, there was chipped, missing tile near the locked room with the toilet. The metal hand rail along the shower wall was observed to have a cut piece that exposed sharp metal area.</p> <p>On 1/7/25 at 9:15 AM, the 1 East shower room was observed with a heavy accumulation of mold/mildew on the grout in between the floor tiles and on numerous wall tiles in the shower. In addition, the ceiling vent cover was coated with dust, and there were approximately 5 water stained ceiling tiles.</p> <p>On 1/7/25 at 9:30 AM, Housekeeping and Laundry Supervisor E was queried about the soiled shower and ceiling vent, but provided no explanation.</p> <p>On 1/7/25 at 2:00 PM, there was a brown soiled towel observed on the floor in the bathroom for room [ROOM NUMBER]. When queried at that time, Resident #32 stated It was left there from yesterday when they cleaned me up.</p> <p>On 1/7/25 at 9:30 AM, 1:20 PM, and 1/8/25 at 8:30 AM, there was an overbed tray table observed in use by multiple residents that was moved back and forth between the main dining room and hallway across from the nursing station. This overbed tray table was observed caked with debris on the metal portions of the table and had missing/lifted top layer with exposed particle board (rendering the surface porous and unable to be properly sanitized).</p> <p>On 1/7/25 at 9:02 AM, R55's room was observed to have a wall behind the headboard that was marred with missing paint.</p> <p>The bathroom shared by residents R12, R26, and R55 was observed to have a broken soap dispenser that had been stored on the back of the toilet bowl tank and there was no further soap available for use.</p> <p>R26's overbed tray table was observed to have lifted edges and was heavily soiled with debris on the metal pole and base. The flooring was scattered with debris and had an accumulation of soil throughout the flooring of the room.</p> <p>R26's privacy curtain was observed soiled with dark debris.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R26 and R55's bedside dressers were observed heavily worn with several drawer fronts that were tilted and broken.</p> <p>On 1/7/25 at 9:57 AM, R46's room was observed to have debris scattered throughout the room and under the bed. When asked about how often housekeeping cleaned the rooms, R46 reported that was the only concern they had and stated housekeeping had not been in their room for about three to four days.</p> <p>On 1/7/25 at 9:30 AM, the room shared by R3, R22 and R30 was observed to have trash and debris scattered throughout the entire room. There were multiple used gloves (turned inside out) scattered around each of the beds. The trash can near the sink did not have a bag and contained various trash inside. The flooring of the room was observed soiled with debris. The baseboard near R30's bed was peeled away and the walls were observed with deep gouges in the drywall.</p> <p>On 1/8/25 at 2:35 PM, during observations of 2 East with the Plant Operations Manager/Maintenance Director (Staff 'F') and the Housekeeping/Laundry Supervisor (Staff 'E'), some of the same observations were made of the above observations. When asked about the condition of some of the overbed tray tables, Staff 'F' reported nursing should be wiping those down, but when they were in that condition, the staff should log that into the maintenance binder so they were aware. At that time, upon review of the maintenance binder for 2 East, there was nothing about overbed tray tables. Staff 'F' reported the overbed tray tables should be replaced as they needed them.</p> <p>Staff 'F' further reported there were many residents on 2 East unit that had behaviors of pulling things off the walls, including the soap dispensers and curtains and were not aware of any concerns specifically for these items. In regard to rooms.</p> <p>When asked about the housekeeping schedule, Staff 'F' reported they had housekeeping staff seven days a week and the last housekeeper left at 7:00 PM. When asked about the condition of the rooms observed and how that was if housekeeping was providing routine services, Staff 'F' reported there were some newer staff that likely needed more education. In regards to the privacy curtains, Staff 'F' reported Staff 'E' should have audits of when those were done. When asked regardless of when they were done, if they were visibly soiled what should have been done, Staff 'F' reported that should've been identified and replaced.</p> <p>Upon observation of the 2 East shower room, both Staff 'F' and Staff 'E' confirmed the build-up on the tile along the shower flooring and gray matter on the wall tiles. Staff 'F' reported the showers should be cleaned daily and was unable to offer any further explanation. In regards to the sharp metal handrail, Staff 'F' reported that should've been reported and was unable to offer any further explanation. Both Staff 'F' and Staff 'E' were requested to provide any additional documentation of monitoring/audit logs and any invoices for furniture/equipment repairs.</p> <p>On 1/9/25 at 8:50 AM, review of the curtain audit revealed the privacy curtains for R26 had last been replaced on 12/17/24. There was no indication in the maintenance log that new concerns were identified.</p> <p>On 1/9/25 at 8:30 AM, the facility was requested to provide any invoices for furniture/room/equipment repairs. There was no further documentation provided for review by the end of the survey.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the facility's policy titled, Cleaning and Disinfection of Resident-Care Equipment dated 8/2024:</p> <p>.Resident-care equipment can be a source of indirect transmission of pathogens .Staff shall follow established infection control principles for cleaning and disinfecting reusable, noncritical equipment .Direct care staff are responsible for cleaning single-resident equipment when visibly soiled .Multiple-resident use equipment shall be cleaned and disinfected after each use .</p> <p>According to the facility's policy titled, Resident Rights dated 2/2024:</p> <p>.Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely .</p> <p>22960</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48680</p> <p>Based on observations, interviews, and record review the facility failed to timely report an injury of unknown origin to the State Agency(SA) for one(R75) of one resident reviewed for abuse, neglect, and injuries of unknown origin. Findings include:</p> <p>On 1/7/25 at 9:32 AM, R75 was observed in bed eating breakfast in their room. R75 had a dark purple/bluish bruise around their right eye and a little discoloration to the surrounding skin of the face. R75 was asked what happened to their eye but was unable to have a coherent conversation.</p> <p>A review of the record revealed that R75 had a diagnosis of dementia, mood disorder, and delusional disorders with a brief interview for mental status score(BIMs) of 0, indicating severe impaired cognition.</p> <p>On 1/7/25 at 9:51AM, R75's guardian was contacted and asked about R75's eye and the guardian explained they visited their loved one on Christmas day and there was no issue with their face. The guardian went on to say that on 12/31/24 they received a phone call from the facility stating that R75 had a red area on their face from sleeping on the remote and was okay with that explanation and thanked the facility for letting them know. About two days later the doctor called back and stated they were going to send R75 out to the hospital to rule out a facial fracture because their eye was swollen shut, a knot was on their forehead and it was painful to the touch. The guardian continued to explain that they went up to the facility at that time and was shocked to see R75's face looking like that. There was a knot on the right side of the forehead and their face was so swollen. The guardian stated, .I honestly feel as if [R75] fell out of bed or somewhere and hit their face because [R75] did tend to fall and not say anything because they couldn't remember to do so. The guardian stated, It's hard to believe a bed remote did this but .</p> <p>On 1/8/25 at 11:30 AM Certified Nursing Assistant (CNA) L was interviewed and asked about the bruising on R75's face. CNA L stated,On 12/31/24 when I first got on shift and did rounds around 7am [R75] was still sleeping so I did not wake them until 8:10 AM when breakfast trays were delivered. That's when I moved [R75] around to perform activities of daily (ADL) care and noticed her face was red and imprinted from the bed remote that she had been lying on. I went to get the unit manager and I let them know what I had found and she came into the room to assess the resident. CNA L was then asked if the reddened area on R75's face got progressively worse throughout the day, CNA L replied, No, it was fine for the remainder of my shift but, when I returned to work and saw [R75] I was shocked to see their face bruised the way it was from a bed remote. CNA L was then asked if R75 falls frequently. CNA L explained that the resident hadn't fell recently or its not often to their knowledge. CNA L was then asked if anyone wanders on the unit. CNA L explained that there were residents that wandered on the unit (which was the dementia unit). CNA</p> <p>L was then asked is there were any aggressive behaviors or combative residents on that unit. CNA L stated, Yes, there is some aggressive behaviors but again, it is a dementia unit so you can get a variety of behaviors throughout the shift.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/8/25 at 11:42 AM, Unit Manager(UM) I was interviewed and asked about the bruising on R75's face, UM I replied, During breakfast, [CNA L] came to get me and showed me that [R75] had a reddened area on their face because they were laying on the bed remote. I did a skin and pain assessment and called the medical doctor, the Director of Nursing(DON) and the guardian. UM I was then asked did R75's face get progressively worse by the time you went home that day UM I replied, No, it was still just a little reddened area. UM I was asked how R75's face presented the next day. UMI replied, I was off the next day due to it being a holiday, but I did notice that it was more of a bruise than the initial day. UM I was asked what did they do once it was noted to get worse who did you report it to, UM I replied, The DON since we had already discussed where it allegedly came from.</p> <p>A review of the facility's investigation report revealed that R75 was observed lying on a bed remote and that their face had a reddened area on it. The facility had interviewed the nurses and CNA's that were on duty for that day 12/31/24 and 1/1/25 when they discussed that the resident is prone to bruising and skin integrity issues.</p> <p>On 1/8/25 at 1:00PM an interview with the administrator, acting administrator and the DON was conducted. They were asked why the incident with R75 was not reported as an injury of unknown origin. The administrator stated that she did not think they needed to report the incident since they knew where the bruise was located and how it happened. The administrator was asked how they concluded the remote control caused the incident after R75's injuries appeared more severe (black eye and knot on top of head). The administrator responded that when they did the investigation they concluded that the injury came from the bed remote and had even sent the resident out for further evaluation to the hospital. The administrator stated that on the night of 1/1/25 the midnight nurse did notify them of bruising on R75's face let the nurse know that they already knew what had happened and thanked the nurse for letting them know. With further questioning the administrator was asked why didn't they report the injury of unknown origin to the state agency when hearing about the new facial bruising since no one had reported bruising but just a reddened area. The administrator replied, It was assumed that it was remote from the initial injury so we knew where the bruise allegedly came from and we didn't think we needed to report something that we knew.</p> <p>No additional information was provided by the exit of the survey.</p>

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415</p> <p>Based on observation, interview, and record reviews the facility failed to follow the recommendation of a (Omnibus Budget Reconciliation Act) Level II Evaluation for one (R28) of one of one resident reviewed for PASARR's (Preadmission Screen Resident Review). Findings include:</p> <p>On 1/7/25 at 9:32 AM, R28 was observed in their room listening to music. R28 refused an interview at that time.</p> <p>A review of the medical record revealed R28 was admitted to the facility on [DATE] with diagnosis that included: bipolar disorder, depression, anxiety, and Schizoaffective disorder.</p> <p>Review of a NSO (Neighborhood Services Organization) letter dated 5/10/24, documented in part . If the above -named individual remains in the nursing facility, a Level II Evaluation is needed by November 06, 2024 .</p> <p>A review of the medical record revealed no additional documentation of the Level II evaluation to have been completed or requested.</p> <p>On 1/8/25 at 12:21 PM, the facility's Social Services Manager (SSM) H was interviewed and asked about the Level II evaluation that was due by 11/6/24 and SSM H stated they would look into it and follow back up.</p> <p>On 1/9/25 at 8:14 AM, SSM H returned and stated the follow up Level II evaluation for R28 was not completed or submitted.</p> <p>Review of a facility policy titled Resident Assessment-Coordination with PASARR Program revised 12/23, documented in part . All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority . Recommendations . from a PASARR level II determination and/or PASARR evaluation report will be incorporated .</p> <p>No further explanation or documentation was provided by the end of the survey.</p>

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>41415</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure Nursing services consistently met professional standards (for R15 and R45), for one of three nurses observed for the medication administration task. Findings include:</p> <p>On 1/8/25 at 8:11 AM, Licensed Practical Nurse (LPN) A was observed preparing the morning medications for R15. Shortly after the nurse was observed to provide R15 with a cup of their morning medications and leave the room to obtain a blood pressure cuff. LPN A did not observe R15 to ensure the resident consumed their morning medications. LPN A reentered the room with the blood pressure cuff and proceeded to obtain the blood pressure of R15's roommate (R45). R15 was not visible from the roommates side of the room as the privacy curtain was pulled, blocking all visibility of R15. At 8:30 AM, LPN A was observed obtaining the glucose blood sugar level via glucometer from R45. R45 verbalized how they had already eaten eggs, ham, toast and their coffee so the reading would probably be high. R45's blood sugar level was noted at 157 (slightly elevated). Shortly after, LPN A was observed preparing the medications for R45. LPN A entered the room, administered the Humalog and Lantus insulin to the resident in the back of the upper right arm. LPN A then administered artificial eye drops to each eye for R45. LPN A was then observed to have left the room to sign off on R45's medications. R45's cup of pills were left at the bedside table for the resident to consume. LPN A did not reenter the room to ensure the resident consumed their morning medications.</p> <p>Review of R15 and R45's medical record revealed no documentation of either resident to have a self-administration of medication assessment completed.</p> <p>Review of a facility policy titled Medication Administration dated June 2019, documented in part . The resident is always observed after medication administration to ensure that the dose was completely ingested .</p> <p>On 1/8/25 at 1:52 PM, the Director of Nursing (DON) was informed of the above observation and asked the facility's protocol on Medication Administration, the DON replied the nurse should have observed the residents taking their medications. The DON was then asked if LPN A should have obtained the blood sugar level before R45 ate instead of after the resident ate and the DON stated the nurse should have obtained the blood sugar before the meal to ensure an accurate reading.</p> <p>No further explanation or documentation was provided by the end of the survey.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>32568</p> <p>Based on observation, interview, and record review, the facility failed to ensure accurate accounting for R38's controlled medication in one of three medication carts reviewed. Findings include:</p> <p>On 1/9/25 at 9:11 AM, an observation of the 1 [NAME] Unit medication cart was conducted with Licensed Practical Nurse (LPN) 'C'. A review of R38's Controlled Substance Proof-Of-Use form for Hydrocodone-Acetaminophen revealed there were 103 pills remaining in the supply as documented by a previous shift's nurse on 1/9/25 at 4:00 AM. At that time, LPN 'C' counted the number of pills in the blister pack which was 101. LPN 'C' reported she gave one pill to R38 and dropped one on the ground, but had not yet documented on the proof-of-use sheet. When queried about the protocol for accounting for controlled medications that were not given, LPN 'C' reported she threw it in the sharps container. When queried about whether there were any protocols in place to ensure the medication was wasted, LPN 'C' reported LPN 'B' witnessed it. Neither nurse signed off on the Proof-Of-Use form. LPN 'C' reported that sometimes it was busy and they had to document later. At that time, LPN 'C' brought the Proof-Of Use form to LPN 'B' to have her sign off that the pill was wasted. LPN 'B' confirmed that she witnessed the pill being wasted but did not sign off on the form per the facility's protocol.</p> <p>On 1/9/25 at 9:34 AM, an interview was conducted with the Director of Nursing (DON). When queried about the facility's protocols for accounting for controlled medications, the DON reported when a nurse pulled a controlled medication from the supply, they documented on the proof-of-use form and updated the count and also documented on the Medication Administration Record when the medication was administered to the resident. If a controlled medication was wasted, a second nurse witnessed it and signed off on the proof of use form.</p> <p>On 1/9/25 at 9:46 AM, a request for a policy regarding administration of controlled substances was made. A policy was not provided prior to the end of the survey.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>32568</p> <p>Based on observation, interview, and record review, the facility failed to properly store and label medications in two of three medications carts reviewed. Findings include:</p> <p>On 1/9/25 at 9:00 AM, an observation of the 1 Central Unit medication cart was conducted with with Licensed Practical Nurse (LPN) 'B'. A Novolog insulin pen was observed in the cart without a label that included the resident's name or a date when it was opened. LPN 'B' reported she knew whose medication it was because that resident was the only one on that unit who was prescribed that medication. LPN 'B' reported insulin pens were stored in the refrigerator prior to being opened and once opened they should be labeled with the date and should also include the resident's name.</p> <p>During that observation, a Lantus insulin pen was labeled with an opened date of 1/30/25 which was inaccurate, as that date had not yet occurred. LPN 'B' reported she was not sure of the opened date based on what was labeled on the pen.</p> <p>On 1/9/25 at 9:11 AM, an observation of the 1 [NAME] Unit medication cart was conducted with LPN 'C'. It was observed that a resident's antidepressant medication was stored in the 1 [NAME] medication cart, but that resident resided on another hallway. LPN 'C' reported it should have been in the 1 Central medication cart. LPN 'C' removed the antidepressant medication and placed it on top of the cart. At approximately 9:15 AM, LPN 'C' left the unit and left the medication on top of the cart.</p> <p>On 1/9/25 at approximately 9:34 AM, an interview was conducted with the Director of Nursing (DON). When queried about the protocol for storing and labeling opened insulin pens, the DON reported the pens were labeled with the date they were opened and should also include the resident's name.</p> <p>A review of a facility policy titled, Storage of Medications, dated June 2019, revealed, in part, the following: . The medication supply is accessible only to nurses, pharmacists, and pharmacy technicians .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41415</p> <p>Based on observation, interview, and record reviews the facility failed to ensure infection control practices and protocols were consistently implemented for three residents (R15,R45 and R55) during medication administration and dining. Findings include:</p> <p>Medication Administration Task</p> <p>On 1/8/25 at 8:17 AM, Licensed Practical Nurse (LPN) A was observed to obtain the blood pressure, heart rate, temperature and pulse oximetry of R15. LPN A returned the blood pressure cuff and pulse oximetry device to their medication cart without cleaning the equipment. LPN A was then observed to have obtained the glucometer from their medication cart and cleaned it with a disinfectant wipe. Shortly after, LPN A was observed to have obtained the blood sugar level of R15 and returned the glucometer to their cart without cleaning the glucometer. At 8:28 AM, LPN A was observed to have obtained the vitals for R45 with the same blood pressure cuff and pulse oximetry device used for R15. The patient care equipment was not cleaned before applying the blood pressure cuff or pulse oximetry to R45. LPN A did not complete hand hygiene of any type after the care of R15 and before the care of R45. Shortly after, LPN A obtained the glucometer from their cart, cleaned it with a disinfectant wipe and obtained the blood glucose level of R45. LPN A returned the glucometer to their cart without cleaning the glucometer. Shortly after, LPN A was observed to have donned on gloves and administered two insulin injections to R45 and immediately after with the same gloves administered artificial eye drops to R45. LPN A failed to complete proper hand hygiene between both administrations.</p> <p>A review of a facility policy titled Cleaning and Disinfection of Resident-Care Equipment revised 8/24 documented in part . Resident-care equipment can be a source of indirect transmission of pathogens . Non-critical items come in contact with intact skin .These items require cleaning and low/intermittent level disinfection .Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident .</p> <p>A review of the manufacturer's guide for the facility's blood glucose monitoring system dated 2017, documented in part .Cleaning and disinfecting your meter and lancing device is very important in the prevention of infectious disease .Cleaning also allows for subsequent disinfection to ensure germs and disease causing agents are destroyed on the meter and lancing device surface .</p> <p>A review of a facility policy titled Hand Hygiene dated 1/24 documented in part .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents .</p> <p>A review of a facility policy titled Injectable Medication Administration dated June 2019, documented in part . Wash your hands with soap and water .Put on gloves .Inject medication .Remove and discard gloves; wash your hands thoroughly with soap and water .</p> <p>A review of a facility policy titled Eye Drop Administration dated June 2019, documented in part .Wash your hands with soap and water, and put on gloves .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/8/25 at 1:52 PM, the Director of Nursing (DON) was interviewed and informed about the observation with LPN A. The DON replied the nurse should have washed their hands in between residents care. The DON stated the nurse should have cleaned the glucometer and patient care equipment after each use. Lastly the DON stated the nurse should have washed their hands after the administration of the insulin and before and after the administration of the eye drops.</p> <p>No further explanation or documentation was provided.</p> <p>30675</p> <p>Dining for R55</p> <p>On 1/7/25 at 9:10 AM, during a meal observation for R55, Certified Nursing Assistant (CNA 'J') was observed to pull up a chair next to the resident who was laying in bed. At that time, CNA 'J' placed the resident's breakfast tray on their lap and proceeded to assist the resident with their breakfast meal. The only overbed tray table was observed on the roommate's side of the room and that tray was observed to have lifted edges and was heavily soiled with debris on the metal pole and base.</p> <p>On 1/7/25 at 11:40 AM, CNA 'J' was asked about the observation of placing the meal tray on their lap while feeding the resident breakfast and they denied any concerns with that observation.</p> <p>On 1/8/25 at 3:50 PM, an interview was conducted with the Administrator. When asked about the facility's process for feeding residents and whether staff should be feeding the resident's meals from the meal tray while placed directly on the staff's lap, the Administrator reported that should never have occurred. They were informed of the observation with CNA 'D' from 1/7/24.</p> <p>According to the facility's policy titled, Dining Services dated 01/2025:</p> <p>.Staff will be educated on hygienic practices such as .Preventing food from coming in contact with staff clothing .</p>		

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Keep all essential equipment working safely.</p> <p>22960</p> <p>Based on observation, interview, and record review, the facility failed to ensure the ice machine in the main kitchen and the ice machine on the first floor, were backflow protected. This deficient practice had the potential to affect all residents in the facility. Findings include:</p> <p>On 1/7/25 at 8:50 AM, the ice machine drain line in the main kitchen, was observed to extend down approximately 2 inches into the floor drain.</p> <p>On 1/7/25 at 9:05 AM, the ice machine drain line for the first floor ice machine, was observed to extend down approximately 2 inches into the floor drain.</p> <p>On 1/7/25 at 11:50 AM, Dietary Manager N was queried about the lack of air gap on both facility ice machines, and stated she was unsure, but would have Maintenance take care of it.</p> <p>According to the Food & Drug Administration (FDA) 2017 Model Food Code, Section 5-402.11 Backflow Prevention, (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed.</p>

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<p>F 0923</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have enough outside ventilation via a window or mechanical ventilation, or both.</p> <p>30675</p> <p>Based on observation, interview and record review, the facility failed to maintain ventilation, resulting in odors and stagnant air, affecting all residents that utilize the 2 East Shower Room.</p> <p>Findings include:</p> <p>On 1/7/25 at 10:15 AM, observation of the 2 East shower room revealed upon opening the door to the shower room, the air was stale and malodorous. When attempting to place a piece of tissue under the ceiling vent to test the air flow (should suck up to the vent if working adequately) there was no suction observed.</p> <p>On 1/08/25 02:32 PM, further observations were conducted of the 2 East shower room with the Plant Operations Manager/Maintenance Director (Staff 'F') and the Housekeeping/Laundry Supervisor (Staff 'E'). When asked about the ceiling ventilation and whether it was functioning, Staff 'F' reported they would test with a piece of toilet paper. When Staff 'F' attempted to test, the toilet paper did not suction to the vent and they reported that was not working at this time. When asked how often those were monitored, there was no further explanation provided.</p> <p>Review of additional documentation of maintenance logs revealed there were no concerns documented regarding the lack of the shower room ventilation.</p> <p>On 1/9/25 at 8:30 AM, the facility was requested for a policy regarding bathroom ventilation and at 11:19 AM, the facility was requested to provide any invoices for furniture/room/equipment repairs. There was no further documentation provided for review by the end of the survey.</p>