STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235207	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakpointe Senior Care and Rehab Center	18901 Meyers Rd Detroit, MI 48235

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation contains two Deficienct Practice Statements Deficient Practice Statement #1. Based on observation, interview, and record review the facility failed to ensure that staff followed enhanced barrier precautions (EBP) and donned appropriate Personal Protective Equipment (PPE) for one resident (R1) out of two residents reviewed for EBP. This failure resulted in the potential for transmission of infectious organisms. Findings include: On 06/10/25 at 11:12 A.M., during an observation of resident care, licensed practical nurse (LPN) B was observed administering a 100 ml (milliliter) water flush through R1's percutaneous endoscopic gastrostomy (PEG) tube. LPN B did not don a gown prior to providing the care. Signage on R1's door indicated Enhanced Barrier Precautions and PPE (including gowns) being available outside R1's room. An interview was conducted with LPN B immediately following the observation. LPN B acknowledged that they should have worn a gown and gloves while administering the PEG tube flush and recognized there was EBP signage and PPE at the room door. On 6/11/25 at 9:50 A.M., an interview was conducted with the Director of Nursing (DON), who said staff are expected to follow the facility's Enhanced Barrier Precautions policy, which requires donning gown and gloves when performing high contact care activities such as device care (including feeding tubes.) The DON acknowledged that LPN B did not follow the required infection control protocols. A review of R1's clinical record noted that R1 was admitted on [DATE] with diagnosis including convulsions, dementia, failure to thrive, dysphagia (difficulty swallowing), and gastronomy status (PEG tube). A Minimum Data Set (MDS) assessment dated [DATE] indicated R1 was cognitively impaired with a score of 11 out of 15 on the Brief Interview for Mental Status (BIMS). A review of facility policy titled Enhanced Barrier Precaution with a revision date of 4/1/24, defined EBP as the expanded use of PPE, including gowns and gloves during high contact care involving medical devices such as central lines, feeding tubes, urinary catheters and tracheostomies. Deficient Practice Statement #2. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure the proper storage of oxygen tubing when not in use for three residents (R30, R37, and R82) of three residents reviewed for oxygen therapy. This failure had the potential for cross contamination and the spread of infection. Findings include: On 6/10/25 at 2:13 P.M., R37 was observed seated in a [NAME] chair in the hallway. R37 nasal cannula tubing was hanging behind the chair and exposed to open air. There was no storage bag present for the nasal cannula to be placed in when not in use. On 6/10/ 25 at 2:14 P.M., LPN D also observed R37 sitting in the [NAME] chair with the nasal cannula tubing on the back of the chair with no bag present. LPN D was queried regarding the nasal cannula tubing and said it should have been in a bag. Record review revealed R37 was admitted on [DATE] with a diagnosis including obstructive sleep apnea and chronic respiratory failure. A (MDS) assessment dated [DATE] indicated that R37 was cognitively intact with a score of 13 out of 15 on BIMS. On 6/10/25 at 2:15 P.M., R82 was observed in bed. R82 nasal cannula tubing was connected to the back of their wheelchair. The nasal cannula tubing was attached to the back of their wheelchair and lying unsecured on the seat. No bag was present for storing the tubing. Record review showed R82 was admitted on [DATE] with a pertinent diagnosis of asthma, weakness and generalized anxiety disorder. A MDS assessment dated [DATE] indicated that R82 was cognitively intact with a score of 13 out of 15 on the BIMS. On 6/10/25 at 2:20 P.M., R30 was observed in a wheelchair being transferred back to R30's room. R30 had a oxygen tank on the back of the wheelchair but was not wearing an oxygen mask. Upon rising from the wheelchair, it was observed that R30 was sitting on the nasal cannula tubing. There was no bag on back of the wheelchair to store the nasal cannula tubing when it was not in use. R30's clinical record documented R30 was admitted [DATE] with a pertinent diagnosis of physical disability, right heart failure, pulmonary embolism, and cerebral infarction (stroke). On 6/10/25 at 2:30 P.M., Certified Nurse Assistant (CNA) C who transported R37 to the room was interviewed and acknowledged the nasal cannula tubing was not stored properly and should have been in a bag. On 6/10/25 at 2:35 P.M., the clinical coordinator (LPN) A accompanied the surveyor to the rooms of R82 and R37. LPN A was queried and confirmed the nasal cannula tubing was lying on the wheelchair seats. LPN A acknowledged the nasal cannulas should have been bagged. On 6/11/25 at 9:50 A.M., an interview was conducted with the DON, who said that staff are expected to follow the facility's on oxygen storage. The DON said oxygen should be stored in a plastic bag when not in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Oxygen Administration and Safety, with a revision date of 5/21/25, indicated the purpose of the policy is to ensure the safe administration of oxygen therapy to residents. The policy documented that oxygen tubing should be stored in a plastic bag when not in use.