STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235259	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Warren	11525 E Ten Mile Rd Warren, MI 48089

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on observation, interview, and record review, the facility failed to ensure water was accessible for one resident (R115) of one resident reviewed for accommodation of needs. Findings include: On 5/5/25 at 8:02 AM, R115 was observed in their room in bed with their water cup being out of reach on their dresser. R115 was interviewed and asked about the accessibility of their water cup and indicated they could not reach it and did not want to get up to get it because they didn't want to fall. On 5/7/25 at 10:27 AM, an observation was made of R115 having no water cup. R115 was observed to be in their room in bed. R115 was interviewed and asked about the location of their water and indicated that someone had come into their room and taken it. R115 was asked if they felt thirsty and stated, sometimes. On 5/7/25 at 1:30 PM, the Director of Nursing (DON) was interviewed about their expectations regarding accessibility of fresh water for residents when in their rooms and indicated fresh water should be available. A record review of R115's electronic medical record (EMR) revealed that R115 was admitted to the facility on [DATE] with diagnoses that included Cerebral palsy (congenital disorder of movement, muscle tone, or posture) and Difficulty in walking. R115's most recent minimum data set assessment (MDS) dated [DATE] revealed that R115 had a moderately impaired cognition and required setup help-substantial assistance for all activities of daily living (ADLs) other than eating. A review of R115's care plan revealed that R115 was at risk for falls and dehydration and had interventions on their care plan to prevent falls and monitor for signs and symptoms of dehydration. On 5/7/25 at 10:35 AM, a facility policy regarding accommodation of needs related to provision of water for residents was requested and not received prior to survey exit.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on interview and record review, the facility failed to timely issue a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF/ABN - notice informing of pay charges) for one resident (R73) of three reviewed for beneficiary notification. Findings include: An ABN list provided by the facility revealed R73 had a Medicare Part A discharge date of [DATE] and remained living in the facility. Review of the notices provided by the facility for R73's revealed there was no SNF/ABN notice issued to R73's resident and/or representative (RR) informing them of the potential pay charges for continued services at the facility. On 5/7/25 at 12:30 PM, Business Office Manager A (BOM) was interviewed regarding the missing SNF/ABN notice for R73 and indicated it was an oversight (R73's RR did not recieve notice) . On 5/7/25 at 1:02 PM, the Administrator was interviewed regarding their expectation for beneficiary notification and comfirmed they should be issued timely.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49102 Based on interview and record review, the facility failed to ensure a Change in Condition level one screening Form DCH (Department of Community Health/3877) was submitted to the local Community Mental Health Services Program (CMHSP) for a level two OBRA (Omnibus Budget Reconciliation Act) evaluation upon a change in the resident's condition for two (R16 and R64) of two residents reviewed for Preadmission Screening/Annual Resident Review (PASARR). Findings include: R64 A clinical record review revealed R64 was admitted to the facility on [DATE] with diagnoses of hemiparesis following a stroke, schizoaffective disorder, anxiety disorder, and major depressive disorder. A Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13/15 indicated an intact cognition. On 5/06/25, a review of the available PASARR form revealed a 3877 form dated 4/18/24 and it was completted as a change of condition with no noted follow up. There was no evidence of R64 being referred for a level II evaluation or evaluation completed to their diagnoses of mental disorders. On 5/06/25 at 9:44 AM, a request was made to the facility requesting documentation of R64's PASARR documentation (Level II evaluation/3878-dementia exemption). On 05/07/25 at 9:30 AM, an interview with completed with Social Worker B regarding R64 and the incomplete [NAME] II screen. Social Worker B confirmed the level II was not done. On 05/07/25 at 12:30 PM, an interview occurred with the Nursing Home Administrator (NHA) regarding expectations for the PASARRs and [NAME] II screens. The NHA stated the expectation is that PASARRs' and level II evaluations should be completed timely per policy. 40384 R16 A review of R16's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Major Depressive Disorder, Generalized Anxiety Disorder, and Spinal Stenosis. Further review revealed the resident was cognitively intact and required one person assist for bathing. Further review of the medical record revealed an active physician order dated 3/12/25, Cymbalta (anti-depressant) Oral Capsule Delayed Release Particles 30 MG (milligrams) .Give 1 capsule by mouth one time a day. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed a PASARR Level I Change in Condition screening form dated for 5/3/24 in which the the following questions were documented as No. 1. The person has a current diagnosis of Mental Illness or Dementia .The person has received treatment for Mental Illness or Dementia . The person has routinely receive one or more prescribed antipsychotic or antidepressant medications within the last 14 days . On 5/7/25 at 10:15 AM, Social Worker B was interviewed regarding R16's PASARR and acknowledged the form was completed inaccurately. On 5/7/25 at 2:28 PM, the Director of Nursing (DON) was asked about social work services and acknowledged the need for additional social workers in the facility. A review of the facility's Resident Assessment-Coordination with PASARR program revealed the following, 5 . a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, ID or related condition to the appropriate state designated authority for Level II PASARR evaluation and determination.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on interview and record review, the facility failed to initiate a Post-Traumatic Stress Disorder (PTSD) care plan for one resident (R87) of two reviewed for care plans. Findings include: A review of R87's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Cerebral Infarction, Heart Failure, and Major Depressive Disorder. Further review revealed the resident was cognitively impaired and required one person assistance for bathing and dressing. Further review of R87's medical record revealed two Omnibus Budget Reconciliation Act (OBRA) evaluations (A document that records the results of the in-person evaluation used to assess a person's need for specialized services). Both evaluations were completed in 2024 and 2025 noted the resident was diagnosed with Post-Traumatic Stress Disorder. Further review of R87's medical record revealed a care plan which did not address R87's diagnosis. On 5/7/25 at 10:15 AM, Social Worker B was asked about the missing care plan for R87's diagnosis and acknowledged that it should have been added. On 5/7/25 at 2:28 PM, the Director of Nursing (DON) was asked about social work services and acknowledged the need for additional social workers in the facility. A review of the facility's Comprehensive Care Plan policy revealed, .4. If the comprehensive assessment and comprehensive care plan identified a change in the resident's goals, or physical, mental, or psychosocial functioning, which was otherwise not identified in the baseline care plan, those changes shall be incorporated into an updated summary provided to the resident and his or her representative, if applicable .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on interview and record, review the facility failed to update interventions on a psychiatric care plan for one resident (R95) of two residents reviewed for care plans. Findings include: On 5/5/25 at 1:57 PM, an observation was made of R95 lying in their bed, awake, yelling, screaming, and swearing. A review of R95's electronic medical record (EMR) revealed R95 was admitted to the facility on [DATE] with diagnoses that included Mood disorder and Major Depressive disorder. R95's most recent minimum data set assessment (MDS) dated [DATE] revealed R95 had a moderately impaired cognition with no mood indicators listed on the assessment. A review of R95's orders revealed that R95 was prescribed the following: Remeron (treament for depression) Oral Tablet 15 mg (milligrams) Give one tablet by mouth at bedtime for mood. A review of R95's care plan revealed the following psychiatric care plan goal/intervention: Focus: I use antidepressant medication r/t (related to) Depression .Interventions/Tasks: I am followed by [Psychiatric provider agency] for psychoactive medication. Date Initiated: 6/10/22. On 5/7/25 at 3:01 PM, Social Worker B was interviewed regarding psychiatric treatment services provided for R95 and R95's care plan and interventions were reviewed with Social Worker B. Social Worker B indicated the psychiatric service provider agency listed on R95's care plan no longer was involved with R95's treatment. Social Worker B was asked if R95's interventions listed on their psychiatrc care plan should be updated to reflect current treatment practices. Social Worker B indicated the interventions should be updated. On 5/7/25 at 3:15 PM, the Director of Nursing (DON) was interviewed regarding their expectations for updating of interventions on care plans and confrimed interventions should be updated when needed. A review of a facility policy titled, Care Planning Date Reviewed/Revised: .6/24 was reviewed and did not address the updating of interventions when care planning.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on interview and record review, the facility failed to obtain a gastroenterology and infectious disease consultation for one resident (R105) of one reviewed for consults. Findings include: A review of R105's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Dysphagia, Peripheral Vascular Disease, and Anxiety. Further review revealed the resident was cognitively intact and independent for transfers and bed mobility. A review of R105's medical record revealed the following progress note: Physician Progress Note: 5/30/2024 14:55 (2:55pm) Practitioner Progress Notes. Chief complaint: Hepatitis C and preventive screening .[R105] with PMH (previous medical history) of polysubstance abuse, Hepatitis C, Hepatitis B, COPD (chronic obstructive pulmonary disease), severe protein calorie malnutrition, hepatitis, alcoholism, diabetes, insomnia, sinusitis, and thyroid disease. Resident seen today to discuss chronic disease management, specifically [their] hepatitis C. [R105] has a history of polysubstance abuse and states [they were] told 'a long time ago' that [they have] hepatitis C but [they do] not believe [they had] ever been treated for it. We also discussed colonoscopy recommendations and GI (gastrointestinal) follow up to which [they] is agreeable. Further review of the medical record revealed the following two active orders: CONSULT to gastroenterology [physician] for colonoscopy/routine colorectal cancer screening. [Digestive Facility]. This order was dated 6/6/24. CONSULT to [physician] for evaluation and management of chronic hepatitis c. History of polysubstance abuse. This order was dated 5/30/24. On 5/6/25 at 2:40 PM, the Director of Nursing (DON) was asked about the missing consults and acknowledged they had not been followed through on. A review of the facility's Physician Orders and Clarification Orders did not address carrying out physician orders.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 Based on observation, interview, and record review, the facility failed to ensure a supra-pubic catheter (SP-catheter inserted via an incision through the abdomen into the bladder) urinary catheter was changed timely for one resident (R73) of one resident reviewed for catheter care. Findings include: R73 On 05/06/25 at 9:01 AM, R73 was observed to be seated in a wheelchair. The urinary catheter tubing was observed to be coiled up on the right thigh with the connection point to the drainage bag visible. The tubing appeared faded and soiled with areas of black along the length of the visible tubing. On 05/06/25 at 10:18 AM, the observation of the urinary catheter was reviewed with Licensed Practical Nurse (LPN) E'. LPN E reported R73 had a supra-pubic catheter and they believed R73 was out regularly to the urologist and had been out to the hospital recently. A review of the record revealed the last urology appointment was on 02/05/24, in which the physician documented related to the urinary catheter .ECF(extended care facility) to change every 6 weeks . Notes: Patient needs SP changed every six weeks with 20 F (french) 10 cc (cubic centimeters) balloon, clean stat lock weekly, and clean around the catheter, Vaseline to be applied after showering . Additional review of a hospital discharge summary dated 10/14/24 documented R73 had a urinary tract infection, R73 has had the suprapubic catheter since 2023 and the catheter was changed during the hospital stay. A review of the nephrology (kidney) doctor's notes did not document a change of the suprapubic catheter. A nephrology consult note dated 02/27/25 documented, .Urology follow up exit site for SP catheter . On 05/06/25 at 10:35 AM, R73 reported they were not sure when they last saw a urologist or had the urinary catheter changed. The drainage tube was observed to be clouded with sediment. At 10:39 AM further review with LPN E confirmed the last catheter change was not found. Further review of the record revealed orders revised 03/17/25 were for a catheter (generally inserted into the bladder via the urethra) and to use an 18 French (gauge) catheter. The timing for change was not specified. An order dated revised 01/22/25 and discontinued 03/11/25 documented the catheter as a suprapubic catheter and the size to be an 18 french. On 05/06/25 at 2:09 PM, the unit manager, LPN F for R73 reported a conversation with the urologist about when the next follow up was needed and it was not indicated at this time. On 05/07/25 at 9:15 AM the physician for R73, Physician G reported there was no real time frame, but generally a resident with a suprapubic catheter is out to the urologist monthly to have it changed and it was not usually done by the facility. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/25 at 5:30 PM and on 05/07/25 at 1:52 PM, the Director of Nursing (DON) was asked for documentation of the catheter changes that had been completed and reported they would look into it. The DON had reported they were not able to provide additional documentation. No further documentation of any suprapubic catheter changes for R73 was provided prior to survey exit. A review of the record for R73 revealed R73 was admitted into the facility on [DATE] with a readmission on 01/21/25 and 03/14/25. Diagnoses included Heart Failure, Chronic Kidney Disease and High Blood pressure. The Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition and the need for partial/moderate assistance with toileting hygiene. Hospital discharge information for the readmissions was not found in the electronic medical record. A review of the catheter information provided from the book Physiological Basis for Nursing Practice did not address the timing for change of the suprapubic catheter. A review of the facility policy titled, Physician Orders and Clarification Orders dated 12/01/21, revealed, .The clarification order is needed to initiate treatment according (to) the plan of care .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on interview and record review, the facility failed to complete monthly medication regimen reviews (MRRs) and follow up physician notification of pharmacy recommendations for four residents (R62, R68, R73 and R105) of five reviewed for unnecessary medications. Findings include: R105 A review of R105's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Dysphagia, Peripheral Vascular Disease, and Anxiety. Further review revealed the resident was cognitively intact and independent for transfers and bed mobility. Further review of R105's medical record revealed a missing medication regimen review for July 2024. In addition, the dates of: 11/20/24, 12/27/25, and 3/15/25 noted the following, [x] See report for any noted irregularities. On 5/6/25 at 1:40 PM and 2:14 PM, and again on 5/7/25 at 8:30 AM, R105's July MRR and irregularities reports were requested from the facility however, they were not received by the end of this survey. 32220 R62 A review of the record for R62 revealed R62 was admitted into the facility on [DATE] with a readmission on 11/06/24. Diagnoses included Schizoaffective Disorder, Biploar Disorder and Insomnia. A review of the pharmacy medication regimen reviews revealed the review for July 2024 had not been completed. R68 A review of the record for R68 revealed R68 was admitted into the facility on [DATE]. Diagnoses included Dysphagia (Difficulty Swallowing) and Alzheimer's. The Minimum Data Set (MDS) assessment dated [DATE] documented impaired cognition, substantial/maximal assistance was needed for eating. A review of the pharmacy medication regimen reviews revealed the review for July 2024 had not been completed. R73 A review of the record for R73 revealed R73 was admitted into the facility on [DATE] with a readmission on 01/21/25 and 03/14/25. Diagnoses included Heart Failure, Kidney Disease and High Blood pressure. A review of the pharmacy medication regimen reviews revealed the review for July 2024 had not been completed. (continued on next page)

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	235259	A. Building B. Wing	05/07/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/25 at 2:28 PM, the Director of Nursing (DON) was asked about the missing MRRs and confirmed they never received the July MRRs. Regarding the irregularity reports, they explained they were unsure of what occurred as they had been provided to the unit managers upon receipt. A policy and procedure for pharmacy services related to pharmacy reviews was requested via email on 05/07/2025 at 12:46 PM, but not received prior to survey exit.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 Based on observation, interview, and record review, the facility failed to ensure one delayed release medication and two extended release medications were not crushed prior to administration and a cranberry tablet dosage was correctly administered out of 33 medications observed, resulting in a medication error rate of 12.12%. Findings include: On 05/07/25 at 9:29 AM, a medication pass observation for R68 was conducted with Licensed Practical Nurse (LPN)C. The following medications were prepared, crushed and placed into applesauce: Aspirin 81 mg (milligrams) tablet one time a day, Megestrol 400 mg/10ml, liquid, 10 ml (milliliters) two times a day; Zunveyl (Benzgalantamine Gluconate) Oral Tablet Delayed Release 10 mg two times a day; Loratadine 10 mg one time a day; Cranberry 400 mg tablet one time a day, (450 mg tablet given); Losartan 100 mg tablet in the morning; Metoprolol succinate 100 mg ER (extended release) tablet; Amlodipine 5 mg tablet in the morning; and Klor-con potassium ER 20 MCG (micrograms) tablet one time a day. The Zunveyl was for Alzheimer's and the Metoprolol was for blood pressure control. The observation was noted to the Director of Nursing (DON) at this time and the DON acknowledged the error concern. On 05/07/25 at 1:54 PM, Nurse Practitioner D reported the delayed release and extended release medications should not be crushed. The Nurse Practitioner further noted they had not been made aware these medications were being crushed. A review of the record for R68 revealed R68 was admitted into the facility on [DATE]. Diagnoses included Dysphagia (Difficulty Swallowing) and Alzheimer's. The Minimum Data Set (MDS) assessment dated [DATE] documented impaired cognition, substantial/maximal assistance was needed for eating and a mechanically altered diet (ground/minced) for food was required. A review of the facility policy titled, Medication Crushing Guidelines dated June 2019, revealed, .The solid dosage forms of many medications should not be crushed for a variety of reasons . Timed release tablets are designed to release over a sustained period, usually 8-24 hours. These formulations are designed to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases. In either case these tablets should not be crushed .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: On 05/05/25 between 7:15 AM-7:45 AM, during an initial tour of the kitchen, the following items were observed: In the walk-in cooler, there was a large piece of cardboard on the floor underneath the rack holding the milk crates. The surface of the cardboard was covered with a spotty, black mold-like substance. In addition, there was an opened 1 gallon container of Italian dressing with a use-by date of 4/28. According to the 2017 FDA Food Code section 4-101.19 Nonfood-Contact Surfaces, NonFOOD-CONTACT SURFACES of EQUIPMENT that are exposed to splash, spillage, or other FOOD soiling or that require frequent cleaning shall be constructed of a CORROSION-RESISTANT, nonabsorbent, and SMOOTH material. According to the 2017 FDA Food Code section 6-101.11 Surface Characteristics, (A) Except as specified in (B) of this section, materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: .(3) Nonabsorbent for areas subject to moisture such as food preparation areas, walk-in refrigerators, warewashing areas, toilet rooms, mobile food establishment servicing areas, and areas subject to flushing or spray cleaning methods. The ice scoop holder located in the dining room was observed with a black, slimy gel accumulated on the bottom inside surface. The tip of the ice scoop was resting in the slimy gel. According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: .(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food) . On 05/05/25 at 7:50 AM, when queried about the moldy cardboard in the walk-in cooler, Food Service Manager (FSM) H stated it would be removed right away. When shown the soiled ice scoop holder, FSM H stated it would be cleaned right away. On 05/05/25 at 7:30 AM, there were individual covered bowls of oatmeal (approximately 45 bowls) on a tray next to the steam table . The oatmeal was not being held hot. On 05/05/25 at 8:00 AM, there were 6 bowls of oatmeal left on the tray, to be served to the last few residents for breakfast. The internal temperature of the oatmeal was measured to be 125 degrees Fahrenheit. When queried, FSM H provided no explanation as to why the oatmeal was not being held at 135 degrees Fahrenheit or above. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235259	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Warren	11525 E Ten Mile Rd Warren, MI 48089

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding, 1. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be maintained: 1. (1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54 C (130 F) or above; P.