STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Flint	G 3201 Beecher Rd Flint, MI 48532

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00144608. Based on observation, interview and record review, the facility failed to prevent the development of a pressure wound and implement timely interventions and documentation for two residents (Resident (#9 and Resident #10) of three residents reviewed for pressure ulcers, resulting in Resident #10 developing an unstageable facility-acquired pressure wound to the left plantar foot and the potential for worsening of wounds, infection, pain and decline in overall well-being for Resident #9 and Resident #10. Findings include: Resident #10: A review of Resident #10's medical record revealed an admission into the facility on [DATE] and readmission on 4/24/23 with diagnoses that included heart failure, diabetes, and acquired absence of right great toe. A review of the Minimum Data Set (MDS) assessment, dated 4/30/24, revealed the Resident had moderately impaired cognition and the Resident was dependent on helper for toileting hygiene, bathing, lower body dressing, mobility and transferring. The MDS revealed the Resident was at risk for developing pressure ulcers/injuries but did not have one or more unhealed pressure ulcers/injuries. A review of Resident #10's MDS dated [DATE], revealed type of assessment, significant change in status, and under Section M-Skin Conditions, the Resident had one unhealed pressure ulcers/injuries, Staged as Unstageable-Deep tissue injury. The progress note dated 7/18/24 revealed, .Nursing observations, evaluation, and recommendations are: Resident observed to have a quarter sized area on left plantar foot of a non blanchable area. Resident foot was cleansed and dressing was applied. Provider informed . A review of Resident #10's wound care visits revealed the following: (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Dated 7/24/24, .During nursing skin assessment the patient was noted to have a left plantar foot wound. Wound care was asked to evaluate and treat. Patient does have a history of right plantar foot wound .Wound Location: Left plantar foot, [NAME]: Deep tissue injury, Description: Wound base shows deep purple/violaceous coloration. There is no open areas. There is no odor or exudate. Area is nontender. Periwound area is dry and scaly. There is no sign of abscess at this time. No sign of infection. Dimensions: 0. 8 cm (centimeters) x (by) 0.8 cm . Plan: .Please keep patient's feet from pressing the bed foot board . -Dated 8/7/24, .Description: Wound base shows deep purple/violaceous coloration. There is no open areas. There is no odor or exudate. Area is nontender. Periwound area is dry and scaly. There is no sign of abscess at this time. No sign of infection. Dimensions: 0.5 cm x 0.3 cm . Plan: .Please keep patient's feet from pressing the bed footboard . On 8/8/24 at 1:20 PM, an observation was made of Resident #10 lying in bed on his back with the head of the bed elevated. The Resident was asked questions, answered questions and engaged in limited conversation. When asked about wounds, the Resident indicated one on the left foot. The foot was up against the footboard that was covered with a blanket. When asked about getting out of bed, the Resident reported they did not have a wheelchair for him. When asked about repositioning, the Resident reported doing it themselves. When asked if he repositioned every two hours or more often, the Resident stated, So-so. On 8/12/24 at 1:43 PM, an observation was made with Unit Manager, Nurse H of Resident #10's dressing on his left foot. The Nurse reported providing wound care later in the morning. An observation was made of Resident #10's foot at the footboard of the bed. The Nurse reported the Resident liked to push against the footboard of the bed. The dressing was clean and intact and dated for 8/12/24. The Resident was lying in bed on his back with the head of the bed elevated, a pillow under his lower legs and his feet were at the footboard of the bed. On 8/12/24 at 2:37 PM, an interview was conducted with Director of Nursing (DON) regarding Resident #10's pressure wound to the left foot. The DON reviewed the Resident's medical record and reported the origination of the wound to be on 7/18/24 with measurements of a quarter and indicated the area should be measured accurately. The DON confirmed the wound was a facility acquired pressure injury and had a history of a pressure wound to the right foot. Review of the wound care documentation revealed the area was assessed on 7/24/24 by the wound care team with measurements of .8 cm x .8 cm. On 8/14/24 at 4:07 PM, an interview was conducted with Wound Care Nurse J regarding Resident #10's pressure injury to the left foot. The Nurse reported the wound was acquired while the Resident was in the facility. When asked about the Resident putting his feet on the footboard of his bed, the Nurse indicated the Resident would scoot down in the bed and reported staff need to make sure he was positioned up further in the bed. The Nurse reported that they had gotten the Resident a longer bed and that staff need to boost him up and flex the knees up on the bed, so it prevents the Resident from scooting down. The Nurse reported no padding to the footboard and reported putting extra padding of the ABD (dressing) pad because he likes to snuggle down. A review of Resident #10's care plan revealed a focus I am at risk for impaired skin integrity r/t (related to): Incontinence Decreased bed mobility, DM II (diabetes), revision on 7/31/24. Interventions included: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Flint		STREET ADDRESS, CITY, STATE, ZIP CODE G 3201 Beecher Rd Flint, MI 48532	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Assess for and encourage adequate hydration, date initiated 7/31/24. -Assist me to moisturize my skin as needed, date initiated 2/25/23. -Assist me to turn &/or reposition routinely during CNA rounds while in bed and frequently redistribute my weight if/when I am up in my chair, date initiated 7/31/24. -Assist/encourage me to elevate my heels off the bed, date initiated 7/31/24. -Incontinent: Cleanse area and apply barrier cream to buttock/periarea after incontinence episodes, per my preference and as I permit, date initiated 2/25/23. -Inspect skin daily with care-Report any concerns to nurse, date initiated 7/31/24. -Licensed Nurse skin assessment per protocol, date initiated 2/25/23. -Please lift, do not slide me. Utilize an assistive device as applicable to decrease friction, date initiated 2/25/23. -Pressure reducing cushion in wheelchair, date initiated 7/31/24. -Pressure reducing mattress on bed, date initiated 7/31/24. Further review of Resident #10's care plan revealed a Focus: Resident preference is to not have a footboard on his bed, date initiated 6/16/23 and revision on 7/31/24, with a Goal Resident will be provided with bed, without footboard, date initiated 6/16/23 and revision on 8/8/24. 22348 Resident #9 (R9): R9 was [AGE] years old and admitted to the facility on [DATE]. A review of Electronic Medical Record (EMR) on 8/12/24 revealed that R9 was admitted with the diagnosis of Acute Respiratory Failure with Hypoxia, Dysphagia, and Lymphedema in addition to other diagnoses. R9's Brief Interview of Mental Status (BIMS) Assessment done on July 31,2024 was zero. A score of zero means the person's cognition was severely impaired. The Admission skin assessment was performed on 8/6/2024 at 22:46. No description, measurement, or characteristics were provided during the skin admission assessments dated 8/6/24. During observation conducted on 8/12/24 at 1:20 PM, R9 was awake but was non-verbal, lying in bed in her room with no evidence of an attempt to offload both her ankles. Nurse E was asked if the wound nurse was available to do treatment but Nurse E stated treatment was already done in AM. R9 care plan initiated on 7/8/2024 revealed an actual impairment to skin integrity: coccyx, bilateral heels, left thigh, right ankle, nose, right forehead (dried scabbed area). Interventions to the skin care plan were initiated dated 7/08/2024: 1. Follow facility protocols for treatment of injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Monitor/document location, size, and treatment of skin injury. Report abnormalities., failure to heal, s/sx of infection, maceration, etc., to MD 3. Practice proper infection control interventions 4. Wound care consultant as ordered. On 8/12/24 at 1:15, a review of Progress notes revealed R9's Wound Progress notes that were noted as Late Entries by the wound nurse on the following dates: 1. Effective date: 7/3/24 at 13:11 Created date: 7/10/24 at 13:27 (LATE ENTRY) Created by Wound Nurse (signed electronically) Type: Weekly Wound Note Location/Type/Stage: Left Heel -Blister- 0.5 CM X 0.5 CM Right Lateral ankle -Excoriation- 0.3 CM X 0.3 CM Right Hip -Deep Tissue Injury 3.5 CM X 2.8 CM Left Hallux- Excoriation- 0.6 CM X 0.8 CM Coccyx- MASD- 2.5 CM X 3.5 CM X 0.0 CM . 2. Effective date: 7/17/24 at 13:19 Created date: 7/21/24 at 13:34 (LATE ENTRY) Created by the Wound Nurse (signed electronically) Type: Weekly Wound Note Location/Type/Stage: Left heel/lateral ankle Blister- 0.8CM X 0.8 CMX 0.0 cm Right lateral ankle- excoriation - 0.2 CM X 0.2 CM X 0.0 CM Right Hip-Deep tissue injury- -2.0 CM X 1.0 CM X 0.4 CM Left Hallux -Excoriation- 0.3 CM X 0.3 CM X 0.1 CM Coccyx-MASD - 2.0 CM X 4.0 CM 0.0 CM . 3. Effective Date 7/24/24 at 3:36 PM Created Date 8/8/2024 15:50 (LATE ENTRY) Created by the Wound Nurse (signed electronically) Type: Weekly Wound Notes (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Location/ Type/Stage: Left Heel -Blister- 0.5 CM X 0.5 CM Right Lateral ankle -Excoriation- 0.2 CM X 0.2 CM Right Hip -Deep Tissue Injury 3.5 CM X 1.0 CM X 0.2 CM Coccyx- MASD- 3.5 cm X 4.0 CM X 0.1 CM Left Ischium- 2.5 CM X 1.0 CM * (New developed) On 8/14/24 at 15:00, a review of the Wound Care Progress Notes dated 7/31/24, Created by the wound doctor (signed electronically) Assessments: 1. Deep Tissue Injury Right Hip 2. Dermatitis associated with Moisture Coccyx, Left Ischium, Excoriation wound on left lateral ankle Right knee Right Ischium Right Lateral Ankle 3. Decreased Independence with bed mobility 4. Incontinence Plan: Wound Treatments 1. Cleanse open areas with normal saline or wound cleansing solution and dry. 2. Right hip, left lateral ankle - apply betadine soaked to the wound surface and cover with kerlix gauze dressing or border foam dressing change QOD/PRN 3. Right Ischium, Right Knee, and left Ischium ---RESOLVED. Please Paint these areas with betadine and cover daily week post-resolution. 4. Coccyx, Left Ischium--- Please Apply Santyl to the wound surface and cover with normal Saline moistened gauze. Cover dressing with kerlix gauze dressing. Please change daily/PRN. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Please apply foam wedges or pillows to offload pressure, reposition frequently, and provide nutritional support and hydration. Follow-up visit next week. E-signed by Wound Physician 7/31/24 at 3:36 PM On 8/12/24 at 1:00 PM, the August 2024 Treatment Administration Record was reviewed. It was noted that the Wound Physician addressed the treatment for the Right Ischium and the Left Ischium area consult dated 7/31/24. The new treatment recommendations were not included in the August TAR. Therefore, the wound specialist/Physician's recommendations were not followed as ordered. It was also noted that R9's Care Plan for R9's wounds was not updated as they resolved, new wounds developed, or existing wounds worsened. During an interview with the Director of Nursing (DON) on 8/12/24 at 2:20 PM, she explained that if it is not documented in the Treatment Administration Record (TAR), It did not happen. When asked about the consistent pattern of at least one week delay in entering the weekly wound documentation as a Late Entry, the DON agreed that there was indeed a delay in the documentation, assessment, and skin sweep not completed, and is an issue for wound care. The facility's policy on Wound Treatment Management and Documentation (Revised date: 2/2024) Policy: To promote wound healing of various types of wounds, it is the facility's policy to provide evidence-based treatments in accordance with current standards of practice and physician's orders. MPHS utilizes the [NAME] & [NAME] Clinical Nursing Skills/Techniques and the National Pressure Ulcer Advisory Panel. Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician's orders . 6. Treatments will be documented on the Treatment Administration Record . 8. Wound Assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. Wound treatments are documented at the time of each treatment . 9. The following elements are documented as part of a complete wound assessment: a. Type of wound (pressure injury, surgical, etc.) and anatomical location. b. Stage of the wound if pressure injury (stage 1, 2, 3, 4, unstageable, deep tissue injury) c. Measurements: height, width, depth, undermining, tunneling d. Description of wound characteristics: i. Color of the wound bed ii. Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium) iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated) (continued on next page)

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	235363	A. Building B. Wing	08/14/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iv. Presence, amount, and characteristics of wound drainage/exudate v. Presence or absence of odor vi. Presence or absence of pain. On 8/12/24 at 3:54 PM, it was discussed with the Administrator and the DON that R9's record revealed some issues with the implementation of treatment as ordered by the wound physician, delayed documentation and assessments, and the wound/skin care plan was not updated and revised.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Numbers MI00144801, MI00146247, MI00146288 and MI00146298. Based on observation, interview, and record review, the facility failed to provide equipment (mechanical lift) which was safe and ensure that it was in good repair to transfer residents for one resident (Resident #12) of three residents reviewed for falls, resulting in a fall, while being transferred using a mechanical lift, resulting in multiple fractures at T11, L1, L2, L3, L4, and L5 and left shoulder dislocation, requiring hospitalization , pain control management for severe pain, surgical intervention, and potential for complications and a decline in medical condition. Findings include: Resident #12 (R12): A review of the Facility's Incident and Accident (I/A) Report dated 8/8/24, noted as follows: -Date and time of incident: 8/8/24 10:20 AM . -Nursing Description: CENAs (Certified Nursing Assistants) was getting her up with Hoyer Lift (mechanical lift) when the strap broke resident fell on her back, cenas notified . -Resident Description: resident stated strap broke and she fell out of lift . -Immediate Action: writer sent guest to hospital (hospital name mentioned) . -The facility described the incident as: Malfunction Hoyer lift. On 8/9/24, a review of the facility investigation revealed the facility identified areas during the facility investigation related to R12's fall sustaining multiple injuries as follows: 1. Hoyer slings were fraying, holes and/or malfunctions after laundry. 2 CNAs witnessed (R12's name) fall and described the fall happened so quickly. They revealed that the sling used during (R12's name) transfer was defective and ripped from the seam, causing the sudden fall straight down, landing on her bottom and lying down across the legs of the lift in an awkward position with (R12's) back (Shoulder) on one of the lifts leg and her hips on the other leg of the lift. 2. Employees are to receive education/ training on the proper use of Hoyer lifts before using the Hoyer lift. 3. Residents requiring a Hoyer lift for transfers were audited for using the appropriate of the sling. On 8/14/24 at 4:00 PM, a review of R12's Emergency Department/Hospital Records revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-(R12's name) arrived at the Emergency Department (ED) on 8/8/24 at 10:33 am and presented as a Fall (approximately 4 feet from the ground) at her facility. Following the fall, the patient was reporting mid and low back pain. Patient admitted for pain control with: Chief complaint: Fall patient was in Hoyer lift at (facility named). Fall from a height greater than 3 feet caused by the strap on Hoyer lift broke, and the patient fell to floor . -During the course at ED on 8/8/24, Radiology revealed the following: Computed Tomography or CT of the thoracic and lumbar spine revealed an oblique fracture involving the anterior half of the T11 vertebral body without significant height loss or retropulsion. Additionally, there is a fracture involving the right transverse of L1, L2, L3, L4, through L5. - Xray Left shoulder and Left Humerus 8/8/24 at 17:30. Final Result revealed: Indication: left shoulder pain . Impression: Antero-inferior left shoulder dislocation. On 8/14/24 at 7:45 am, R12's Electronic Medical Record (EMR) was reviewed. R12 was [AGE] years old admitted to the facility on [DATE] with the following diagnosis: Hemiplegia and Hemiparesis following Cerebral Infarction affecting the left non-dominant side, Type 2 Diabetes Mellitus with Hyperglycemia, and Chronic Obstructive Pulmonary Disease with acute Exacerbation in addition to other diagnoses. R12's Care Plan was reviewed, revealing that R12 has an ADL (Activities of Daily Living) Self Care Performance Deficit related to Hemiplegia S/P CVA. Interventions and tasks specified extensive assistance, particularly for personal hygiene and grooming, extensive assistance in bathing and dressing, needed two to extensive assistance with bed mobility, and was totally dependent on two staff using mechanical lift with two staff assistance with transfers initiated on 5/17/2024. R12's Brief Interview of Mental Status BIMS Score=15/15 assessment dated on 7/25/24 that indicated intact cognition. The facility's Nursing Progress Notes dated 8/8/24 at 9:15 AM revealed: Date of Fall 8/8/24. Pain assessment:10. Vitals B/P=205/167, P-97, R-20, T97.88, O2 Sat 98% The facility's Practitioner Progress Notes dated 8/8/24 at 10:30 AM revealed: Provider received a phone call from the nursing manager and was made aware that the patient had a fall from the Hoyer sling. A verbal order was given to transfer the patient to the ER for evaluation. According to the Director of Nursing (DON) on 8/13/24 at 11:00 am, the DON indicated that R12 fell on [DATE] while on a Hoyer lift, and the sling was defective and broke while transferring R12 from the bed to the wheelchair. The DON described how R12 fell , which was that R12 fell out of the sling and landed on top of the legs of the Hoyer lift. There were 2 CENAS, and two nurses were called in the room after the fall. The strap of the sling broke and the Resident fell on the floor. The DON further explained that the fall was caused by a defective sling used in the Hoyer lift for R12. The strap of the sling ripped while the resident was on the lift and R12 fell out of the lift. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

The Administrator, on 8/13/24 at 11:12 am, explained that: The deficiency was that the staff did not inspect and look at the condition of the sling before they used it on a resident. As a result, R12 fell and was sent to the hospital for further evaluation and severe pain. We later learned that R12 sustained a fracture of T11, L1 up to L5. The Administrator explained, we looked at the incident and the root cause. We assessed every sling in the building and identified the ones to be defective. R12 weight 273. 2 lbs. with total dependence on staff during transfers and mobility was reviewed. When the Administrator was asked if they had kept the sling that R12 was on before falling, she said that they had discarded the sling used during R12's fall and got rid of most of the damaged slings found to be defective and unsafe.

CENA A was interviewed on 8/13/24 at 11:57 am. CENA A recalled that she assisted CENA B in transferring R12 from the bed to the wheelchair, and R12 was already lying on top of the sling by the time CENA A arrived to help CENA B at the scene. CENA A positioned herself by the Hoyer lift post and operated the remote, while CENA B was by R12 as the Resident was lifted. When CENA B turned R12 towards the chair, the strap broke, and R12 slid and fell out of the sling. It just ripped. When CENA A was queried if she had observed or inspected the condition of the sling used before the transfer, she said: I did not see the condition of the sling that was used because (R12) was already on the sling when I got there. I went and got the nurses, and they came to assess (R12) after she had already fallen. The sling ripped from the seam of the sling. (R12) was screaming in pain while she was laying uncomfortably on both legs of the lift. (R12) was crying. The CENA indicated she did not recall any recent Hoyer Lift in-service education but had it when she first started 5 years ago and annually.

An interview with CENA B was conducted. CENA B revealed on 8/13/24 at 11:30 am that she was assigned to R12 when she was getting ready to get R12 up at around 9:00 am on 8/8/24. CENA B has asked another CENA (CENA A) for assistance. CENA B explained that she was a newly hired CENA who had started about two weeks ago. The other CENA (CENA A) was doing the remote and stand by. CENA B recalled that the sling R12 was in ripped, and the resident fell . CENA B was asked how high R12 was on the lift when she fell . The CENA reported, it was high enough above the bed, and as R12 was turned, the sling ripped, and R12 fell so quickly, landed on her bottom first, and then fell on her left side with R12's shoulders and hips positioned across both legs of the lift. CENA B recalled that R12 was screaming in pain and they called for the nurses right away.

Nurse C, during an interview conducted on 8/13/24 at 11:13 am, stated: We were called to (R12's name) room and found (R12) was laying across the two legs of the Hoyer Lift when we got there. One of the lift straps broke, and (R12) fell from the lift. (R12) was yelling in pain. Upon arrival at the scene, (R12) was assessed at the pain scale level of 10/10 on her lower and mid back. We found her lying on the floor with her shoulder and hips resting on both Hoyer Lift legs. (R12) was yelling out in pain. Nurse C recalled that although R12 was screaming in pain at a 10/10 level, Nurse C did not administer any pain medications. Nurse C said she was worried about why the ambulance took so long to arrive and was calling R12's emergency contact. Nurse C indicated the sling was defective and ripped from the seam. Nurse C further stated that the sling must have been ripped before but was not inspected before R12 was lifted. Nurse C indicated that during the audit after the fall, they found more damaged, frayed slings with some having tears and holes on the slings.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024
NAME OF PROVIDER OR SUPPLIER: Mission Point Nsg & Phy Rehab Ctr of Flint		STREET ADDRESS, CITY, STATE, ZIP CODE: G 3201 Beecher Rd Flint, MI 48532	

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 0689 Level of Harm - Actual harm Residents Affected - Few	Nurse D was interviewed on 8/13/24 at 11:46 am. Nurse D revealed she was passing medications assigned to her when Nurse C asked for help with R12. R12 was not assigned to Nurse D at the time of the incident. Nurse D described how R12 was found on the floor when both nurses arrived at the scene. R12's shoulders and thighs were positioned on the Hoyer lift's legs (across the 2 bars)and R12 was crying in pain and discomfort. Nurse D assessed R12, and when she asked what had happened, Nurse D reported that R12 pointed at the broken strap and was saying, I'm hurt repeatedly. R12 was removed from the uncomfortable Hoyer legs and used a different sling transfer her back to bed. Once the transfer was completed, Nurse D left to continue with the medication administration. When Nurse D was asked how R12 fell , Nurse D stated that: I was not there and did not see what happened. Nurse D, however, indicated that she asked the resident what happened and R12 pointed at the strap of the lift, which was broken. An observation was conducted at the facility to find slings on 8/13/24 from 1:00 PM to 1:30 PM. Nurse C with the surveyor, went around the facility to search for slings from the laundry room on the 1st floor to every floor from the 2nd floor, 3rd floor, and 4th floor linen storage rooms and residents' area, but there were no slings available at the entire facility found. The residents were on their slings individually, and the surveyor could not inspect the condition of the slings because the residents were sitting on them. The surveyor asked the nursing manager and the Administrator for any slings in the facility that were currently not in use. No slings were available at the time. The facility policy on mechanical lifts was not the same brand and model used at the facility. The lift that was found in R12's room was colored Blue with LINAK Brand Type: CBJX00XWE112171 ITEM: CBJ2026-02, LINAK Designed in [NAME] DK-6430 Nordborg Type: BAJ100001XX1, Item: BAJ1010-00 Date 01/16/2023 W/O # 805304-011.The lifts at the facility were observed and noted as not a Sunshine Manufacturer/Brand. They were incompatible with the operator's manual used to provide education/in-service to the facility staff. When queried, the Administrator 8/13/24 at 2:30 PM revealed they did not have a facility policy on the use of mechanical lifts. They use the Sunshine Medical (Brand) Mechanical Lift as a reference for the staff during post-incident/fall education after the 8/8/24 fall incident. The Administrator confirmed that the facility used the same reference manual even if the mechanical lifts are from different manufacturers. They do not currently have the manufacturer/product manual for the Linak Mechanical Lift or the Agiliti Mechanical Lift, which is presently used at the facility for residents requiring mechanical lifts for safe transfers. The Administrator stated that they reached out to the Hoyer Lift companies for the procedure/product manual and waiting for reply. A review of the Mechanical Lift Reference Manual revealed the following: .Company/Product Name: Hoyer Heavy Duty Patient Lift Manufactured for Sunrise Medical Model Number: HPL 600 Date of Manual: undated Important Safeguards/ Warning: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Mission Point Nsg & Phy Rehab Ctr of Flint		STREET ADDRESS, CITY, STATE, ZIP CODE G 3201 Beecher Rd Flint, MI 48532	

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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 0689 Level of Harm - Actual harm Residents Affected - Few	. Hoyer floor lifts are specifically designed for Hoyer slings and accessories. Slings and accessories designed by any other manufacturer are prohibited and will void Sunrise Medical's warranty. Use only Hoyer slings and accessories to maintain user safety and product utility . . Hoyer lifts must be used by a caregiver with proper training to work with the person to be transferred . . Do not use a sling that is not recommended for the lift . .Never use a damaged, torn, or frayed sling . A review of the Facility Incident Report dated 8/8/24 at 10:20 am revealed: Nursing Description: CENAS was getting her up with the Hoyer lift when the strap broke. The resident fell on her back, CENAS notified .Resident Description: The strap broke and fell out of the lift .Immediate Action: Sent guest (R12) to the Hospital . Pain: (Numerical) 10 .Injuries Report Post Incident: Unable to determine . Nurse C confirmed on 8/13/24 at 11:13 am that she had filled out the I/A Report and sent R12 to the hospital. However, Nurse C revealed that she did not provide the resident pain relief despite the complaint of 10/10 pain. When asked why, Nurse C justified that she got busy getting R12 ready for the ER and calling the emergency contact. The facility Policies submitted were reviewed on 8/13/24 at 3:00 PM: -Incident Reporting- Accident and supervision (Revised date: 6/23) -Fall Reduction Policy-(Revised date: 4/23) -General Washing Procedure for Slings Sling & Chemical or Heat Sensitive Item Laundering Procedures (not dated) -Hoyer Heavy Duty Patient Lift Model HPL600 (Installation and Instruction Manual (undated) The policies submitted above did not contain the specific educational content to correct the deficiency of ensuring the use of proper slings according to the mechanical lift manufacturer's brand and staff checking the condition of the slings and appropriateness prior to patient use.