

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Shorepointe Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  26001 East Jefferson Avenue Saint Clair Shores, MI 48081	

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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 44750</p> <p>This citation pertains to Intakes: MI00145838, MI00146086, and MI00145914.</p> <p>Based on observation, interview, and record review, the facility failed to provide grooming and showers per schedule and preference for two residents (R701 and R714) out of three reviewed for Activities of Daily Living (ADLs). Findings include:</p> <p>R701</p> <p>A review of Intake MI00145838 revealed the following, [R701] has not been given a shower since being in facility. [R701] has only been given a bed bath twice in the last month.</p> <p>A review of the medical record revealed that R701 admitted into the facility on [DATE] with the following medical diagnoses, Generalized Anxiety Disorder and Depression. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R701 was also dependent on staff for bed mobility and transfers.</p> <p>Further review of the shower documentation for the entirety of R701's stay revealed they only received bed baths while in facility. No showers were documented.</p> <p>On 8/8/2024 at 3:32 PM, an interview was conducted with the Director of Nursing (DON). The DON stated if bed baths were R701's preference it should have been listed in the care plan, as well as a progress note.</p> <p>A review of the progress notes and care plan did not note bed baths being a preference for R701.</p> <p>49699</p> <p>R714</p> <p>On 8/8/2024 at 11:25 AM, R714 was encountered alone in an elevator going from the third floor to the first floor for lunch. It was noted the resident had long (approximately one and one-half inches) facial hair on his lower jaw. The hair extended to the neck under his ears and was longer(three to four inches). R714 said he had tried to shave himself but was unable to do so. The resident revealed they had asked for assistance with shaving a few times and said they (facility staff) don't have time to help me.</p> <p>(continued on next page)</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility record review revealed R714 was admitted on [DATE] after being hospitalized for Epididymitis (infection in testicles). R714 has a fluctuating Brief Interview for Mental Status, (BIMS) score of 7 to 8 indicating severely impaired to moderately impaired cognition.</p> <p>A further review of the facility record revealed a care plan for Activities of Daily Living (ADL) self-care deficit, with an intervention of assist with ADLs: eating toileting, personal hygiene, bathing, bed mobility and wheelchair mobility. A second intervention for bathing/showering indicates the need for 1 person assist.</p> <p>The policy, Activities of Daily Living, with a revised date of 12/7/2023, revealed: Appropriate care and services will be provided for residents who are unable to carry out ADL independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care).</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750</b></p> <p>This citation pertains to Intake MI00145914.</p> <p>Based on observation, interview, and record review, the facility failed to set up a follow up appointment for one resident (R702) out of one reviewed for follow up appointments. Findings Include:</p> <p>A review of Intake MI00145914 noted the following, [R702] has an (indwelling) catheter (tube that goes into the bladder to drain urine) in and was supposed to get that out before coming here, however they only tried taking it out once and never tried to figure out why [they] needed it.</p> <p>On 8/8/2024 at 12:01 PM, R702 was observed sitting in their chair. R702 was noted to have a drainage bag for a catheter hanging on the side of their wheelchair. R702 stated they received the catheter in the hospital and the facility tried to take it out once, but put it back in.</p> <p>A review of the medical record revealed that R702 admitted into the facility on [DATE] with the following medical diagnoses, Depression and Presence of Urogenital Implants. Further review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15 indicating an intact cognition. R702 also required assistance with bed mobility and transfers.</p> <p>Further review of the progress notes revealed the following,</p> <p>7/11/2024 .Resident foley was removed by previous nurse.</p> <p>7/13/24 .Writer bladder scanned resident, 750 ml (milliliters). Writer contacted MD (Medical Director), new order to reinsert (name of catheter). (name of catheter) inserted, no c/o (complaint of) pain or discomfort, 600 ML drained.</p> <p>A review of R702's hospital paperwork noted that R702 was to follow up with neurology within 5-7 days of discharge for the (name of catheter) catheter.</p> <p>On 8/8/2024 at 3:30 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility keeps calling to schedule the appointment for urology and they have been told someone would call them back within 24-48 hours. The DON stated the unit clerk has been trying to make the follow up appointment.</p> <p>On 8/8/2024 at 3:48 PM, and interview was conducted with Unit Clerk (UC) A. UC A stated they have called several times and aren't receiving a call back. UC A was queried as to if this is documented anywhere or if R702's physician has been notified. UC A stated they inform the floor nurses, and they should document and inform the physician.</p> <p>Further review of the progress notes did not reveal documentation regarding the urology appointment of notification to the physician.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	A review of a facility policy titled, Consultations noted the following, For consultations which are provided outside of the facility, the facility will: Schedule the appointment with the consultant, if the resident or family/responsible party does not wish to do so personally .		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>49699</p> <p>This citation pertains to Intake MI00145880.</p> <p>Based on observation, interview, and record review, the facility failed to provide palatable hot meals for four of four residents interviewed. Additionally, meals were not provided according to the provided Tray Delivery Schedule. Findings include:</p> <p>On 8/8/2024 at 10:00 AM, R703 said the tea water not hot, every day receive cold eggs.</p> <p>On 8/8/2024 at 10:30 AM, R704 said the food is barely warm when delivered.</p> <p>On 8/8/2024 at 1045 AM, R705 said the food is not very warm when they receive it.</p> <p>On 8/8/2024 at 11:00 AM, R706 said the food is awful, nothing is ever hot when it should be.</p> <p>On 8/8.2024 at 11:15 AM, while observing food service in the Atrium Dining area, a Dietary Aide (AD) was noted to bring two meals to the steam table area. The two covered meals were set on top of the steam table window. The dietary aide removed the covers and the meals (pork medallion, mashed squash, steamed zucchini meal, and a hamburger with lettuce and tomato), remained on top of the steam table window from 12:02 to 12:10 P.M. then were given to two residents.</p> <p>On 8/8/2024 at 11:59 AM, a test tray was requested to either be the last tray off the line, or taken from the last cart delivered on the floor. At 1:17 PM, an announcement was made that trays for Lakeland 3, the last unit to receive trays, were ready. The test tray was received at 1:40 PM, having gone to the floor first. Sampling of the test tray revealed food was very warm, but not hot. The coffee was very hot, milk and juice were cold. Tasting the food revealed a pork medallion dish that was extremely salty, mashed squash and steamed zucchini were tasteless, and not edible. Two sugar cookies were also on the tray in individual bags that had developed grease marks.</p> <p>On 8/8/2024, the Dietary Manager (DM), was interviewed regarding obtaining temperature from meals. They revealed the food temperature is obtained just prior to plating. Temperature logs provided and temperatures were within limits for both cold and hot foods. They said the trays go out on time, but could not say why the trays did not go out on time this day.</p> <p>On 8/8/2024 a review of the Tray Deliver Schedule revealed the lunch trays were to be delivered from 11:00 AM to 12:30 PM with the unit 3 Lakeland to be the last to receive trays.</p>		