STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235443	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shorepointe Nursing Center	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)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 This citation pertains to Intake MI00149892. Based on interview and record review, the facility failed to ensure notification of a room change was provided for two residents (R906, R908) of three reviewed for room changes. Findings include: On 01/30/25 at 9:22 AM, a review of a complaint related to R906 revealed an allegation R906 responsible party (RP) or family was not notified of R906's room change. A phone call was made to the first emergency contact and financially RP designated in the medical record. An advocate designation dated 09/08/21 documented the RP as the advocate for healthcare. The RP reported they had not been notified until two days after R906 was moved and had to ask which room the resident had been moved to when they arrived to visit. The RP further reported the room to which R906 had been moved had a resident who yelled out often and disturbed R906. The RP further noted R906 had a roommate (R908) who was also moved out of the room. A review of the record for R906 revealed R906 was admitted into the facility 07/21/23. Diagnoses included Dementia, Falls and Pain. The Minimum Data Set (MDS) assessment dated [DATE] documented, severely impaired cognition. A review of the progress notes in the electronic medical record revealed no documentation or indication R906 nor the RP had been notified before R906 was moved to a different room. A review of the census data documented R906 had been in the same room from 07/21/23 until moved on 10/08/24. No additional documentation for notification of the room change was provided for R906 prior to survey exit. On 01/30/25 at 9:55 AM, R908 reported they were informed of the room change on 10/08/24 just before it happened and did not like the room they were moved to as it was smaller. R908 reported they were moved because there was a COVID patient who needed the room and was told they were being moved and was not given an option to preview the new room. A nursing note dated 10/11/2024 at (7:33 PM) 19:33 documented, Received resident alert and responsive. Adjusting to current room change . No documentation for prior notification of the resident or family for the room change on 10/08/24 was found in the electronic medical record. (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: 235443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025
NAME OF PROVIDER OR SUPPLIER Shorepointe Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 26001 East Jefferson Avenue Saint Clair Shores, MI 48081	

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the record for R908 revealed R908 was admitted into the facility 09/28/22. Diagnoses included Dementia and Pulmonary Disease. The MDS dated [DATE] documented intact cognition. The electronic medical record profile page documented a daughter as the responsible party for financial items and the first emergency contact. The active care plan initiated 09/29/22 documented a self care deficit for activities of daily living, a potential risk for falls and an impaired thought process or cognitive function. The care plan indicated to present just one thought, idea, question or command at a time. A review of the facility policy titled, Notification of room/roommate change dated 04/18/23 revealed, .The right to receive written notice, including the reason for the change, before the resident's room or roommate is changed .Complete the Notification of Room/Roommate Change Assessment located in the (electronic medical record). Print the Notification of Room/Roommate Change Assessment after completion. Discuss the change with the resident and or the resident's representative, including the reason for the change. Provide the resident or representative with the notification form .

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F 0689 Level of Harm - Minimal harm or potential for 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** 46956 This citation pertains to Intake M100149834: Based on interview and record review, the facility failed to implement care planned interventions to prevent a fall for one (R902) of three residents reviewed for falls. Findings include: Review of the facility record for R902 revealed a most recent admitted [DATE] with diagnoses that included Spina Bifida with Hydrocephalus, Paraplegia, and Epilepsy. R902's most recent care plan included the Focus item Resident is at risk for falls and potential for injury related to seizure diagnosis, impaired physical mobility, paraplegia, history of falls, medication use. One intervention item associated with this care plan stated Place anti-slip pad in wheelchair seat. Further review of R902's facility record revealed a progress note dated 01/08/25 authored by Licensed Practical Nurse (LPN) J indicating they had been notified by staff that R902 had fallen in their room. LPN J indicated they went to the room and R902 was laying on the floor near the wheelchair and a mechanical lift (device used to transfer residents from one surface to another). LPN J indicated R902 was assessed to have no pain or obvious injury and was transferred to their bed then the physician was notified and requested the resident be transferred to the hospital for further assessment. On 01/29/25 at 12:49 PM, LPN J was interviewed and asked to recount what they recalled about R902's fall on 01/08/25. LPN J reported a staff member notified them R902 had fallen in their room. LPN J reported they went to the room and the resident was on the floor and Certified Nursing Assistant (CNA) K was with the resident. CNA K reported they had put the lift sling under the resident to be transferred back to bed and they realized the sling was the wrong size. CNA K reported they went to get another sling and the resident fell from the wheelchair as they were leaving the room. LPN J reported they assessed the resident to have no obvious injuries and then staff transferred the resident back to bed with staff assistance. LPN J reported they called the physician to report the fall and it was recommended the resident be transferred to the hospital to be further assessed. On 01/29/25 at 1:08 PM, CNA K was interviewed via phone call and asked to recount what they recalled regarding R902's fall on 01/08/25. CNA K stated they were preparing to transfer R902 from the wheelchair back to bed. They reported they put the mechanical lift sling under the resident. CNA K stated once they had the sling in place they realized it was too big so they went to retrieve the proper sling. They stated as they were leaving the room they heard a noise and looked back and R902 was on the floor in a position of having slid forward out of the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/29/25 at 2:37 PM, the facility Director of Nursing (DON) reported their understanding of the fall involving R902 was the CNA put the mechanical lift sling in place under the resident in the wheelchair and realized it was the wrong size. When they left to get another sling the resident slid out of the chair as they were sitting on the sling. The DON indicated that the resident should not have been left sitting on the sling unattended and that they had stressed this with staff in the past. The DON was asked about R902's care plan intervention for non-slip padding being used in the wheelchair and they indicated the resident was at risk for slipping forward from the chair. The DON reported the expectation is when the sling is put under the resident in the wheelchair they should not be left unattended due to the fall risk. A facility policy or documentation otherwise addressing the issue of a physically compromised resident being left unattended sitting on a lift sling was requested. Although the facility did provide policies addressing resident fall protocols and mechanical lift use, the information provided did not specifically address the identified concern.