

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  12/22/2025
NAME OF PROVIDER OR SUPPLIER  Shorepointe Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  26001 East Jefferson Avenue St. 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 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.  (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

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to Intake: 2695258Based on observation, interview, and record review, the facility failed to prevent a fall for one resident (R901) of two residents reviewed for falls. Findings include:A review of information submitted to the State Agency (SA) revealed the following, On or around November 18, 2025, [R901] was being moved .The staff member, a CNA (certified nursing assistant), dropped [R901] . [R901] was transported to the hospital for care .A review of R901's medical record revealed they were initially admitted into the facility on [DATE] with diagnoses which included, Quadriplegia, Anxiety, and Muscle Wasting and Atrophy. Further review revealed the resident was moderately cognitively impaired and required 2-person assistance for bed mobility and transfers.On 12/22/25 at 9:45 AM, R901 was observed lying in bed and asked about the fall they sustained in November. R901 explained they fell out of bed and was sent to the hospital after complaining of pain. R901 explained there was one staff member in the room when they fell but could not recall what occurred prior to. R901 also indicated they had a cut on their eyebrow from the fall. A review of R901's care plan revealed the following, Focus: At risk for changes in behavior and mood r/t (related to) dx (diagnosis) of insomnia, Anxiety, Adjustment disorder with mixed disturbance of emotions and conduct, PTSD (post-traumatic stress disorder) r/t to a fall at a previous SNF (skilled nursing facility). Date Initiated: 12/10/2024 .Interventions: Non-Psychopharmacological interventions: Television, going outside, reading, classical music, when possible, provide ADL Care visits with 2 people. Date Initiated: 03/05/2025 . On 12/22/25 at 10:16 AM, an interview was conducted with CNA A, assigned CNA for R901 on the date they fell. CNA A reported she had been assigned to the resident for approximately one month and was familiar with their anxiousness during care. CNA A explained the resident is not necessarily combative but fearful of falling and will tell you they are scared. CNA A reported she started to provide care by removing the resident's brief, turning them on their left side facing the room window. CNA A explained she was positioned behind the resident and began to wipe them. CNA A explained that the resident became anxious and started grabbing the fitted sheet behind themselves in an attempt to hold onto something to prevent themselves from falling however, as the resident continued grabbing the sheet, they started to roll away from them, resulting in a fall to the floor. CNA A was asked if the resident required one or two people when providing care, and she reported two.A review of R901's ADL (activities of daily living) assist prior to their fall on 11/25/25 revealed the following, ADL Assist of x2 bed mobility, x2 toileting A review of the Incident and Accident report dated for 11/25/25 revealed the following, Nurse was notified by CNA that resident had become combative during care and fell out of bed writer observed resident laying on her stomach next to bed .Writer found resident on [their] stomach, face down, with slight bleeding from a right brow laceration .Resident stated that [they] hit their head, [R901] is lightheaded, dizzy, and pain at a 10 MD (medical doctor) was notified here in house and examined patient, MD order to send resident out for planned CT (computer tomography, an imaging test) .A review of hospital documentation dated 11/25/25 revealed the following, .s/p (status post) Fall .Injuries: right upper eye lid laceration .right thigh abrasive injury with pink bruise which appears to be a new injury .On 12/22/25 at 2:00 PM, an interview was completed with the Director of Nursing (DON) regarding R901's fall. The DON explained that CNA A explained the circumstances of the fall differently and would address it with the CNA through proper education.A request for the facility's Fall policy was requested and received the facility's Accident and Injury policy. After review, it did not address the facility's policy and procedures for preventing a fall.</p>		