

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38271</p> <p>This citation pertains to intake MI00145765 and MI00146157</p> <p>Based on observation interview and record review, the facility failed to ensure an environment free from physical abuse for two residents (R12 and R100) of five residents reviewed for abuse/neglect/mistreatment, resulting in R12 being transferred to the hospital and sustaining soft tissue swelling and hematoma involving the right posterior parietal-occipital scalp and R82 being transferred to the hospital and sustaining peri-orbital ecchymosis and a left eye sub conjunctival hemorrhage.</p> <p>Findings include:</p> <p>R12 and R267</p> <p>On 8/6/24 a facility reported incident (FRI) that was submitted to the Stage Agency was reviewed and revealed R12 was pushed over onto the floor by R267 on 7/12/24.</p> <p>R12</p> <p>On 8/06/24 at approximately 12:59 p.m., R12 was observed in their wheelchair and was queried regarding their altercation with R267. R12 reported they were sitting in the dining room and that another male resident was trying to get to another female resident and they were trying to protect the other female resident. R12 indicated that R267 came over and pushed their wheelchair over because they were mad and they hit their head and had to go to the hospital.</p> <p>On 8/6/24 at approximately 1:39 p.m., R12's DPOA (durable power of attorney) was queried if they had any concerns regarding R12's care and they reported that R12 was attacked by another resident, sent to the hospital and had a hematoma from hitting their head on the floor.</p> <p>On 8/6/24 the medical record for R12 was reviewed and revealed the following: R12 was initially admitted to the facility on [DATE] and had diagnoses including Anxiety disorder and Hemiplegia and Hemiparisis affecting left non-dominant side. A review of R12's MDS (minimum data set) with an ARD (assessment reference date) of 5/29/24 revealed R12 needed assistance from facility staff with most of their activities of daily living. R12's BIMS score (brief interview for mental status) was 11 indicating moderately impaired cognition.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 7/12/2024 revealed the following: Incident Note- Resident was sitting in her wheelchair in the Dining Room at around 5:00pm before dinner, resident was in her w/c (wheelchair) while flipped over on her back by another male resident. Resident stated that I was trying to block him from touching the other female resident. He got angry and push me from my wheelchair. Resident (room and bed number) got upset and denied Aggression was stop by nursing staff .neurochecks initiated, injury to head, hematoma to RT (right) parietal lobe, ice pack to injury, Physician [attending Physician] notified stated' not to give resident any Bp (blood pressure) meds (medications) for elevated bp, ordered writer to send out to hospital .</p> <p>A second progress note dated 7/12/2024 revealed the following: Nursing Progress Note -Event occurred on 07/12/2024 5:00 PM. Resident was noted lying on her back in wheelchair dayroom another male resident pushed her backward .</p> <p>A progress note dated 7/13/2024 revealed the following: Resident returned from [local hospital], via stretcher accompanied by 2 attendants. Resident A&amp;O (alert and orientated) verbally responsive. Resident returned with dx (diagnosis). of Head Contusion, .Resident B/P 175/104, [attending Physician] notified of return and the resident B/P (blood pressure) and was ordered to continue neuro checks for 24 hours. Writer ordered to give resident her pm medications now</p> <p>A Social Service note dated 7/15/2024 revealed the following: Writer met with [R12] for an overall safety and wellbeing check Writer asked [R12] if she has/had any concerns or issues regarding her safety and wellbeing in the facility due to the incident on 7/12/2023 with another peer. [R12] indicated she is 'fine' and has no fears or concerns about her safety. Writer asked [R12] if she would share the events that occurred from that incident. [R12] indicated she was in the common room with peers watching T.V. and observed resident [R267] attempting to hug resident [another female resident] [R12] indicated she was trying to prevent [R267] from getting close to [other female resident], [R267] became angry and pushed her out of her wheelchair</p> <p>A hospital Emergency Department evaluation dated 7/12/24 revealed the following: Chief Complaint</p> <p>Patient presents with Head Injury presents following a fall at her nursing home. Patient was in the community room when she was pushed in her wheelchair by another patient. She fell and reportedly hit her head . Comments: Large contusion in R (right) occipital region with no blood .</p> <p>A CT (Computed tomography) scan dated 7/12/24 revealed the following: Findings .Significant soft tissue swelling and increased attenuation about the right posterior parietal and occipital scalp consistent with hematoma .Impressions .2. soft tissue swelling and hematoma involving the right posterior parietal-occipital scalp .</p> <p>Resident #267</p> <p>On 8/7/24 the medical record for R267 was reviewed and revealed the following. R267 was initially admitted to the facility on [DATE] and had diagnoses including Restlessness and Agitation. A review of R267's MDS (minimum data set) with an ARD (assessment reference date) of 4/10/24 revealed R267 was independent with most of their activities of daily living.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R267's comprehensive careplan revealed the following: Focus-I have the potential to exhibit behaviors that sound or appear sexual in nature r/t (related to) Dementia. Date Initiated: 12/11/2023 . Interventions-If I am interested in another resident and either of us are not competent, please gently separate/redirect us and help me to become interested in another activity. Date Initiated: 12/11/2023 .When I become agitated: Intervene before agitation escalates; guide away from</p> <p>source of distress; engage calmly in conversation; if response is aggressive, staff need to walk away calmly and approach later. Date Initiated: 12/11/2023 .</p> <p>Further review of R267's careplan revealed the following: Focus-have potential to demonstrate physical behaviors (hitting, kicking, resistive to care, slapping, repetitive movements, pushing). I</p> <p>am followed by [facility psychiatric provider]. Date Initiated: 03/13/2024 .Interventions-Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 03/13/2024 .When I become agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and</p> <p>approach later. Date Initiated: 03/13/2024 .</p> <p>A progress note dated 7/12/2024 revealed the following: Incident Note. Resident was sitting in her wheelchair in the Dining Room at around 5:00pm resident suddenly pushed [R12] and caused her to flip over. Resident [R12] stated that I was trying to block him from touching the other resident. Above resident [R267] got angry and push me from my wheelchair .</p> <p>A second progress note dated 7/12/2024 revealed the following: Nursing Progress Note-Resident was reported by other nursing staff to writer that he was physically aggressive to other resident . Resident pushed [R12] that caused her to flip over from her wheelchair. Physical aggression was stopped by writer. Resident was taken out of the dining room Resident was petitioned out to be transferred. Police officers notified. Arrived at 6:25pm verbal report given and Paperworks filled out and printed. Resident was escorted by police officers transferred to [local hospital] .</p> <p>A third progress note dated 7/12/2024 revealed the following: Nursing Progress Note-According to [R12] resident was attempting to reach another resident but she rolled in front of him which stopped him from reaching anyone else in the dining room. That caused him to be upset so he pushes her out of the wheelchair, Resident was taken to his room and assigned CENA (Certified Nursing Assistant)stayed with him until police arrived</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility investigation summary pertaining to the altercation between R12 and R267 on 7/12/24 revealed the following: FINDINGS-On 07-12-2024, writer received call from [facility Nurse] that resident [R267] was entering 2nd floor dining room where residents [other female resident] and [R12] were in dining area. [R12] stated [R267] was going toward [other female resident] and she told him not to bother them, he then became angry and pushed her wheelchair which made her fall backwards out of her chair and hit her head. Nursing staff immediately intervened upon hearing commotion coming from the dining room, upon entering dining room [R12] was on the floor stating he had pushed her wheelchair which made her fall, [R267] was removed from dining room where he was put on 1:1 supervision. [R12] was placed back into wheelchair and assessed she has hematoma on the right side of head, and right jaw. Dr. was notified new order to transfer resident out to hospital for further evaluation .</p> <p>On 8/8/24 at 12:19 p.m., CNA K was queried regarding R12 being pushed over by R267 on 7/12/24 and they indicated that they heard some screaming coming the dining room and that they were the first there and witnessed R12 flipped over in their wheelchair on the floor and that R12 reported that R267 had pushed them over and she had hit her head after they were protecting another female resident from R267's advances. CNA K indicated that no staff were noted in the dining room monitoring R267.</p> <p>R82 and R100</p> <p>On 8/8/24 a concern submitted to the State Agency was reviewed which alleged R82 had assaulted R100 on 7/23/24.</p> <p>R82</p> <p>On 8/8/24 at approximately 11:05 a.m., R82 was observed in their room, laying in their bed. R82 was queried regarding the alteration with R100 on 7/23/24 and they indicated that R82 had gone into their room uninvited and stated messing with their bed sheets and personal items. R82 reported they told R100 to get out of their room and that R100 had hit them twice on their head. R82 reported that after R100 hit them, they hit R100 multiple times in the face and gave them a black eye and went and told the staff about it.</p> <p>On 8/8/24 the medical record was reviewed and revealed the following: R82 was initially admitted to the facility on [DATE] and had diagnoses including Anxiety and Schizoaffective disorder. A review of R82's MDS (minimum data set) and an ARD (assessment reference date) of 7/16/24 revealed R82 was independent with most of their activities of daily living. R82's BIMS score was 13 indicating intact cognition.</p> <p>A review of R82's comprehensive careplan revealed the following: Focus-I have potential to demonstrate physical behaviors AEB (as evidenced by) alleged grabbing another resident around the neck sustained injury during altercation with the other resident. r/t Dementia/Alzheimer's. 7/23/24- physical altercation with another resident. 8/5/24- reported that resident rolls down the hall calling peers and staff morons. Date Initiated: 03/18/2024 .Interventions-Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 03/18/2024 .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 7/23/2024 revealed the following: Nursing Progress Note-Resident Alert, oriented x 4, came to the nursing station screaming, using abusive speech', claiming that the other resident attacked him. Resident directed the attention to his injury. Resident was taken down to meet with Administrator. Resident was removing from 3rd room and transferred to second floor room. Resident skin tear was given first aide .</p> <p>A progress note dated 7/25/2024 revealed the following: Nursing Progress Note-Resident risk meeting held resident for resident to resident altercation, Nursing staff noted new edema in hand from incident .</p> <p>R100</p> <p>On 8/08/24 at approximately 12:54 p.m., R100 was observed in their room, laying in their bed. R100 was queried regarding the altercation with R82. R100 reported he remembers fighting but did not remember what had caused the incident.</p> <p>On 8/8/24 the medical record for R100 was reviewed and revealed the following: R100 was initially admitted to the facility on [DATE] and had diagnoses including Violent behavior, Alzheimer disease, and Wandering. A review of R100's MDS (minimum data set) with an ARD (assessment reference date) of 6/13/24 revealed R100 needed supervision from facility staff with their personal hygiene. R100's BIMS score (brief interview for mental status) was three indicating severely impaired cognition.</p> <p>A progress note dated 7/23/2024 revealed the following: Nursing Progress Note- Resident was injured by another resident. Resident received injuries to both eyes, and scratch on forehead, eyes are black, red and swollen. Nurse did not witness the incident. Nurse received resident from other staff. They walked resident to nursing station Nurse is waiting for doctor to reply with further instructions, relating injuries. Nurse will continue to monitor the resident for safety and his wellbeing.</p> <p>A second progress note dated 7/23/2024 revealed the following: Nursing Progress Note-Resident was injured by another resident. Resident received injuries to both eyes, and scratch on forehead, eyes are black, red and swollen . Immediate intervention implemented: Nurse applied first aide to resident face and scalp</p> <p>A Practitioner Progress Note dated 7/24/2024 revealed the following: [R100] was injured by another resident yesterday 23rd July around afternoon. He received injuries to both eyes, and scratches on his forehead On examination his eyes has fading and improving peri-orbital ecchymosis and a left eye sub conjunctival hemorrhage His daughter and grand daughter visited his today and wanted him sent out Discussed with nurse to sent him to hospital for evaluation.</p> <p>A review of the facility investigation of the altercation between R82 and R100 revealed the following: Findings: Resident [R100] was observed by [CNA L] while giving patient care on 3rd floor that resident [R82] was in his room had thrown [R100] shoe outside into hallway where it hit the wall when she went to put shoe back on (R100), she observed his left eye swollen she took resident to nurse. [R82] was going to nurses station and had stated [R100] hit him when he came into his room on back of his head, and he said he also scratched him on his right arm, when he told him to leave his room. When questioned by the nurse regarding [R100] he said he didn't do anything to him/</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>[R100] was assessed by nurse and it was noted that both his eyes were darkened, resident unable to explain what happened, he also had scratch on his forehead, First Aide provided to resident Dr. and Guardian notified. [R82] was immediately separated from resident and assessed he had scratches on his rt (right) hand he was taken to administrator office where he was questioned by writer regarding the incident, he stated that resident [R100] came into his room and he told him to get out, when asked did he hit the resident he stated yes he hit in the eyes after he scratched him and hit him in the back of head. First Aide provided to resident's hand, no injuries noted to back of head, .Conclusion:</p> <p>No one witnessed what occurred with [R82] and [R100], Police was notified they came to facility and spoke with resident regarding incident he was educated to ask staff for assistance and not to hit any residents, [R82] room was moved to another floor. Both residents receives well being checks by social services, [R82] states he feels safe in the facility. [R100] shows no signs of distress, his eyes are doing well, he was seen by physician on 07-24-2024 his family was at bedside and wanted resident to be sent out to hospital for further evaluation of his eyes, resident transferred out he returned with no new orders. It was substantiated this incident occurred .</p> <p>On 8/7/24 at approximately 2:55 p.m., during a conversation with Social Worker C (SW C), SW C was queried regarding R267's behaviors and their altercation with R12. SW C reported that the staff were aware of R267's behaviors towards females and that they should be monitoring them.</p> <p>On 8/8/24 at approximately 1:18 p.m., during a conversation with the Administrator who served as the facility abuse coordinator, the Administrator was queried regarding the altercation between R12 and R267 and they reported that R267 got made and had knocked over R12's wheelchair when R12 was protecting another resident from them. The Administrator indicate that CNA K went into the room and saw R12 flipped over and separated everyone and the Nurse was made aware and R267 was petitioned out to the hospital and R12 was sent to the hospital for their head injury. The Administrator was queried how the staff were monitoring R267's behaviors and they indicated that they staff knew to watch them and to intervene. The Administrator was queried regarding the altercation between R82 and R100 on 7/23/24 and they reported that R100 was in R82's room and that R82 hit R100 after R100 hit them. The Administrator reported that R82 came down to their office to calm down and informed them of the altercation and what had occurred. The Administrator reported both altercations were substantiated due to their injuries, staff reports and resident reports and that R267 has not returned from the hospital and R82's room had been changed.</p> <p>On 8/8/24 a facility document titled Abuse/Neglect and Exploitation was reviewed and revealed the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38271</p> <p>This citation pertains to intake MI00145584</p> <p>Based on observation, interview and record review the facility failed to ensure a thorough investigation into an allegation of misappropriation was completed and contact law enforcement for one resident (R13) of one residents reviewed for misappropriation.</p> <p>Findings include:</p> <p>On 8/6/24 a facility reported investigation (FRI) was reviewed that alleged the following: Incident Summary Resident (R13) states that he had three \$50.00 bills, totaling \$150.00 in his coat pocket he states he hung jacket up in his closet when he went back to get his coat he states his money was gone. He didn't see anyone in his closet or in his room just the cena (Certified Nursing Assistant Q)who was taking care of his roommate .</p> <p>On 8/8/24 at approximately 2:17 p.m., R13 was observed in their room, up in their wheelchair. R13 was queried regarding the allegation of his money and indicated that he thought the female CNA stole it out of his coat pocket. R13 was queried how much money they had and they could not remember the exact amount they had reported.</p> <p>On 8/8/24 the medical record for R13 was reviewed and revealed the following: R13 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Hypertension. A review of R13's MDS (minimum data set) with an ARD (assessment reference date) of 7/15/24 revealed R13 needed supervision from staff with most of their activities of daily living. R13's BIMS score was 10 indicating moderately impaired cognition.</p> <p>A review of the facility investigation pertaining to the allegation revealed the following: [R13] stated that on 05-17-2024 during day shift he had three \$50.00 bills in his coat pocket, he states his coat was hung up by a cena, [CNA M] he then left his room when he returned he states money was gone. He didn ' t ' see anyone in his room or near his coat. He did say it was a tall cena taking care of his roommate, but he didn ' t see her around his coat. [R13] couldn ' t explain where he got the funds from, facility doesn ' t give out \$50.00 bills, she gives out \$20.00 bills, resident was encouraged to leave his funds in his trust account for safe keeping until he is ready to use it, he verbalized understanding. Investigation findings are as follow: Interview were conducted with [CNA M], [CNA O], and [CNA P] all job classifications are Certified Nurses Assistance, all verbalized they didn't see any money that [R13] had or go near his coat after it was hung up by [CNA M]. Conclusion: Incident was not substantiated, resident was again encouraged to let facility safeguard his funds, any valuables, he will receive weekly support visits from social services for 4 weeks then prn (as needed).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/08/24 at approximately 1:18 p.m., during an interview with the facility Administrator (Abuse Coordinator), the Administrator was queried pertaining to R13's allegation of misappropriated money and they reported they had talked to them and they could not come up with a timeframe of when their money was taken. At that time, the investigation file was reviewed with the Administrator and they queried why they only interviewed three CNA's. and if they had interviewed other residents who resided in close proximity to R13 to ascertain if anyone else had missing funds and they indicated they did not. The Administrator was queried if they had interviewed any other staff who may have come in contact with R13 such as Nurses and CNA's on different shifts and housekeeping, dietary or maintenance staff and they reported they did not. The Administrator was queried if they had notified the police of R13's allegation and they indicated they did not due to the facility not witnessing R13 having that amount of money on their person. The Administrator was queried if they should have completed more pertinent interviews with other staff and residents as well as notify police of the allegation and they indicated that was part of their usual process to complete the investigation.</p> <p>On 8/8/24 a facility document titled Abuse/Neglect and Exploitation was reviewed and revealed the following: Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property V. Investigation</p> <p>A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; a. The facility Administrator is the Abuse Coordinator of the facility. b. The facility Administrator may designate an interim Abuse Coordinator in their absence (i.e., vacation, PTO). 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47283</p> <p>This citation pertains to intake MI00143714.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a sanitary kitchen, maintain equipment in good repair, and safely store food. This deficient practice has the potential to affect all residents that consume food from the kitchen.</p> <p>Findings include:</p> <p>An initial tour of kitchen was completed with Dietary Manager (DM) J on [DATE] (approximately) between 8:45 AM - 10:00 AM. The initial tour included the storage area in the basement of the facility.</p> <p>During the initial tour the kitchen floor dirty. The floor has brown stains food debris throughout the kitchen. The trash can next to hand wash was overflowing and there were trash that included food debris outside the trash can. The surveyor moved the trash can and noticed more dried food waste and other debris behind the trash can.</p> <p>The surveyor queried DM J about the kitchen cleanliness and floor situation and how often they were cleaning the floors. They reported that they had started three weeks ago at the facility and the floor had not been cleaned since they had started. They reported that it should have been cleaned daily; they had been trying to get someone to clean the floor and they would address it.</p> <p>The dry storage room had an open bag of charcoal and two bottles of fire starter liquid stored with other kitchen items on a shelf. When queried DM J reported they were not sure why they were stored in the dry food storage area and they would address it.</p> <p>Outside the DM J office, in the kitchen hallway, there were two small trash cans there were overflowing with no lids with food and other debris. There were dried food and other debris on the floor under the tables.</p> <p>The food prep table with sink had visible dust and debris. The prep sink backsplash was ripped off from the dry wall with an extended gap and a gouge on the drywall. The slicer had visible dust was not covered. A plastic bag filled screws, bolts and other hardware was on the prep table next to the slicer. The prep table had few knives wrapped in a plastic wrap. DM J asked a kitchen staff member and they reported that they were not sure why they were there. A nonfunctional strainer was hanging over the table. When queried DM J reported that they were not sure if staff were using the slicing machine and they had removed the bag as it needed to be replaced. They also reported that they would replace the strainer.</p> <p>According to the 2017 FDA Food Code Section ,d+[DATE].11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Approximately 9:15 AM: The walk-in cooler floor was not clean. The cooler had container of butter cream icing with an open date of [DATE].</p> <p>Walk in freezer had ice buildup on the top. When queried DM J reported that it happened a week ago after an incident when the freezer door was not closed properly and they were following up on it. The freezer had an opened pack of flour tortillas with freezer burn and no date wrapped in a plastic wrap.</p> <p>A cart with spices were stored next to the open drain from the prep sink table. The spice cart frame was in contact with the drain with potential for contamination from prep sink drain water. When queried DM J, they reported that they had reported this to the facility's corporate team and they were aware of the situation. The spice had several containers of opened spices with no open date.</p> <p>The spice rack had a container of cracked black pepper with an expiration date: [DATE]; a container of celery seed expired on [DATE]; and a container of ground thyme expired on [DATE]. An opened bag of powdered sugar wrapped in a plastic bag with no open date. A carton of mashed potatoes with no open date.</p> <p>The rack with clean dishes next to the oven had several cracked tiles underneath. Part of the floor had large metal covering, approximately ,d+[DATE] feet with a large hole. The hole was covered (not secured) with a plastic cover, that appeared like a disposable bowl. When the surveyor queried DM J reported that they did not know why the hole was there and had asked a kitchen staff member. The staff member who reported that they had been working at the facility for many years reported that it had been the same way for many years. The kitchen staff member also reported that it was maintenance storage/office under the hole and they were asked to keep that covered and that was the reason they had the plastic cover over the hole.</p> <p>The three compartment sink drains had leaks from the drainpipes. There were 2 plastic bins placed under the drainpipes and the bins had water. DM J reported that there were leaks in the drainpipes and the corporate team was aware of the issue.</p> <p>Review of the dish machine temperature log had missing entries for [DATE], [DATE], [DATE] and [DATE]. When queried about the process DM J reported that staff should be checking and logging daily before they used the dish machine.</p> <p>The food storage room in the basement had dry food storage area. The dry food storage shelf had two dented cans of lemon pudding that were removed by DM J when it was brought to their attention. The basement storage had a freezer. The bottom shelf of the freezer had heavy ice buildup. A box of chicken thighs was on the bottom shelf next to the ice buildup. When the surveyor opened the freezer door the temperature dropped instantly. The door was opened for approximately 30 seconds and the freezer temperature (on the inbuilt thermometer) went up to 11.7 degrees Celsius (53.06 degrees). When the door was closed there were loud noises from the freezer and it took approximately 5 minutes for temperature to drop to -1 degree (30.2 degrees). When queried DM J they reported that they were not aware of the freezer issue and they would follow up with facility administration.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A follow up observation was completed later that day at approximately 12:40 PM. The kitchen staff were serving lunch from the steam table. DM J was asked to check the temperature of the food that were being served. They had pulled a thermometer that was placed next to the steam table. The thermometer was not working. There were no spare thermometers available to check the temperature. DM J was queried on the process and how staff were checking the food temperature, they reported that they would replace the thermometer.</p> <p>Review of facility's cooking temperature log from [DATE] to [DATE] revealed logs for the [DATE], [DATE], [DATE], [DATE], [DATE], and ,d+[DATE], the included incomplete logs. There were several days of missing entries and there was no evidence that the staff were consistently monitoring the food temperatures. When queried DM J they reported that the staff were not following the facility process and they had initiated the process around [DATE] when they had started and they would follow up.</p> <p>According to 2017 FDA Food Code Cooking sections: ,d+[DATE].11 Raw Animal Foods. ,d+[DATE].12 Microwave Cooking. ,d+[DATE].13 Plant Food Cooking for Hot Holding. Cooking, to be effective in eliminating pathogens, must be adjusted to a number of factors. These include the anticipated level of pathogenic bacteria in the raw product, the initial temperature of the food, and the food's bulk which affects the time to achieve the needed internal product temperature. Other factors to be considered include post cooking heat rise and the time the food must be held at a specified internal temperature .</p> <p>Review of facility's pest control reports from their provider between [DATE] and [DATE] revealed ongoing kitchen cleanliness and sanitation concerns that were brought to the facility's attention that included structural concerns in the concerns.</p> <p>An interview with the facility administrator was completed on [DATE] at approximately 8 AM. Administrator was notified of the observations and they reported that they understood the concerns. They also added that the new dietary manager was in the process of implementing the systems to ensure that their staff were consistently following the facility processes. They also added that the facility was under new management and they were going to fix the structural issues in the kitchen.</p> <p>A facility provided document titled Food Storage with the most recent revision date of ,d+[DATE], read in part, Food storage areas shall be maintained a clean, safe and sanitary manner. This includes maintaining temperatures of coolers and freezers at appropriate temperatures to promote food safety .</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47283</p> <p>This citation pertains to intake MI00143714.</p> <p>Based on observation, interview and record review facility failed to maintain a good general repair of the facility with a safe and functional environment for multiple resident rooms/resident equipments and common areas reviewed for physical environment. This deficient practice has the potential to affect the residents living in those room(s)/using the equipment(s) and all residents who use the common areas/elevators with feelings of frustration and dissatisfaction with their living conditions. Findings include:</p> <p>room [ROOM NUMBER]</p> <p>room [ROOM NUMBER] had three residents. During an observation completed on 8/6/24 at approximately 10:15 AM, the surveyor observed the privacy curtains were not functional between 316-1 and 316-2. 8 of the 17 hooks that suspend the curtain from track on ceiling were broke and the curtain was mostly hanging down. The privacy curtains between beds 316-1 and 316-2 as well as the one between 316-2 and 316-3 were not clean. The latter one (between bed 2 and 3) had a large reddish-brown stain that measured approximately one foot in diameter.</p> <p>room [ROOM NUMBER]-1</p> <p>On 8/6/24 at approximately 11:20 AM an observation was completed on room [ROOM NUMBER]. The surveyor observed resident sitting on their bed in 307-1. The headboard on the bed was broke and partly hanging towards the right side. There was no foot board on the bed. The two metal pieces that secures the foot board was sticking out. During this observation an interview was completed and resident was queried and they reported that I can't speak on it. They added that it broke a while ago and were not sure about time frame and stated may be a month. They added that the foot board was sitting under the bed and someone took it.</p> <p>An interview was completed with Housekeeper R who was outside in the hallway near room [ROOM NUMBER]. They were queried about the broken bed in room [ROOM NUMBER]-1. They reported that the resident broke their bed some time ago. When queried further they reported that would notify the maintenance staff to get them a new bed.</p> <p>Multiple follow up observations were completed later that day at approximately 12:30 PM and 1:30 PM. room [ROOM NUMBER]-1 had the broken bed and resident was sitting on their bed. On 8/7/24 at approximately 8:30 AM the broken bed was in room [ROOM NUMBER]-1 with missing foot board and broken headboard. When the surveyor queried if anyone had come to check the bed the resident stated No.</p> <p>room [ROOM NUMBER]-2</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation completed on 8/6/24 at approximately 8:30 AM. A resident was sitting up on their bed. The bedside table was missing veneer/molding around the table with porous non-cleanable and sharp areas around. When surveyor queried they reported that they had the same table for a while and the facility could fix it.</p> <p>room [ROOM NUMBER]-1</p> <p>During an observation completed on 8/6/24 at approximately 12 PM, resident in room [ROOM NUMBER]-1 was sitting on their bed and watching their phone. When the surveyor queried about their stay the facility they reported they had been at the facility for approximately one month and they had been asking for television in their room. They had to use their phone watch something so they did not get bored. When queried if staff were aware they reported to facility staff resident reported that maintenance staff were aware and they did not know what was happening. A follow up observation was completed on 8/7/24 at approximately 11:15 AM and the resident did not have a television in their room and they reported that they had not seen anyone from maintenance.</p> <p>room [ROOM NUMBER]-2</p> <p>During an observation completed on 8/6/24 at approximately 12:15 PM in room [ROOM NUMBER]. Resident in 311-2 had summoned the surveyor when they are speaking with their roommate and asked the surveyor to check their TV and stated look, I need a new TV. The screen appeared defective and broke internally with distorted pictures three quarters of the screen. Right 1/4 part of screen had picture. When queried if facility staff were aware of their concern they reported that facility staff were aware and they did not know what was happening.</p> <p>The surveyor observed ceiling tiles with brown stains the hallway outside of room [ROOM NUMBER]-bath/shower room.</p> <p>The floor indicator lights on the elevators were not working. On 8/7/24 at approximately 8:15 AM, surveyor was waiting in the elevator and had activated the 3rd floor and was waiting for the doors to close. After approximately 30 seconds the surveyor activated/pushed the switch again and the doors did not close. After a few more attempts the surveyor came out of the elevator to get assistance from the staff. The surveyor observed the Director of Nursing (DON) walking down the hall. Surveyor explained that they were attempting to go 3rd floor and doors did not close and had activated the floor switch more than once. DON reported that the elevators were slow but they were working and had asked the surveyor to just activate the floor switch once and wait for the doors to close. They added that it would take a few minutes, but if it gets activated multiple times it might freeze.</p> <p>An interview was completed with Maintenance Director MS T on 8/8/24 at approximately 10:20 AM. MS T was queried about their maintenance notification process and their preventative maintenance rounds. They reported they had maintenance log on every floor. They had two maintenance assistants and they were checking them daily and staff at times notified them verbally when they were on the floor. When queried about the missing foot board, bedside tables with missing veneers, television issues they reported that had addressed as soon as it was brought to their attention. They also reported that resident in 307 broke the footboard and they had replaced it and they had different kinds of bed frames at the facility and did not have the right part and had provided a different bed frame after the surveyor brought up the concern. Record review also revealed that facility had a behavior care plan on resident's record after the broken bed was brought to the facility's attention.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235454	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Elmwood		STREET ADDRESS, CITY, STATE, ZIP CODE  1881 E Grand Blvd Detroit, MI 48211	
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview with the administrator was completed on 8/8/24 at approximately 8 AM. Administrator was notified of the concerns physical environment and they reported that they understood the concerns and they would follow up. They had also reported that facility was under new management and they were in the process of making improvements with the physical environment.</p> <p>A facility provide document titled Safe and Homelike Environment with an implementation date of 1/11/21 read in part, In accordance with Resident's Rights the facility will provide as safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes the resident's independence and does not pose a safety risk .</p> <p>38271</p> <p>R112</p> <p>On 8/06/24 at approximately 9:47 a.m., R112 was observed in their room, laying in their bed. R112's wheelchair was observed to have multiple ripped spots on the top of their wheelchair and missing half of the foam on the right arm rest. R112 was queried regarding the wheelchair and indicated that they needed a new one but they have had the same one for a long time.</p> <p>On 8/08/24 at approximately 2:29 p.m., R112 was observed in their room. R112's wheelchair was still observed to have the same multiple ripped spots on their wheelchair and missing half of the right arm rest foam.</p> <p>On 8/08/24 at approximately 2:33 p.m., Nurse U was queried regarding the worn status of R112's wheelchair and they indicated that they would let the staff know to get R112 a new wheelchair.</p> <p>ON 8/6/24 the medical record for R112 was reviewed and revealed the following: R112 was initially admitted to the facility on [DATE] and had diagnoses including Cerebral Infarction and Heart failure. A review of R112's MDS (minimum data set) with an ARD (assessment reference date of 6/4/24 revealed R112 needed supervision with their personal hygiene. R112's BIMS score (brief interview for mental status) was 11 indicating moderately impaired cognition.</p>		