STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235454	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Elmwood	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to intake MI00147590. Based on interview and record review, the facility failed to provide adequate assessment after an injury for one resident (R105), resulting in missed opportunities to identify the potential latent effects of the injury. Findings include: It was reported to the State Agency that the resident did not receive adequate and appropriate care while in the facility. A review of the clinical record for R105 documented an initial admitted [DATE] and re-admitted [DATE]. R105 was transferred to the hospital on 10/15/24 and did not return to the facility. R105's diagnoses included vascular dementia, atherosclerotic heart disease, hypertension, and diabetes mellitus-type 2. A Minimum Data Set, dated dated [DATE], documented severe cognitive impairment. On 10/29/24 at 3:50 PM, an interview and review of R105's clinical record was conducted with the Director of Nursing (DON). R105's clinical record documented in part the following: 1. SBAR (Situation-Background-Assessment-Recommendation) summary for providers completed on 10/15/24 at 12:01 AM by Licensed Practical Nurse (LPN) M. The change in condition reported were bleeding (other than GI) skin wound or ulcer. At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 126/76 - 10/13/2024 3:31 PM. Position: Sitting right arm - Pulse: P 56 - 10/13/2024 3:31 PM. Pulse Type: Regular - Respiratory Rate: R 18.0 - 10/13/2024 3:31 PM - Temp: T 96.9 - 10/13/2024 3:31 PM. Route: Forehead (non-contact) - Pulse Oximetry: Oxygen 97.0 % - 10/13/2024 3:31 PM. Method: Room Air (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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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	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Blood Glucose: Blood sugar 145.0 - 10/14/2024 9:56 PM. Relevant medical history is: Dementia Advance directives are: hospice care Resident/Patient had the following medications changes in the past week: none Outcomes of Physical Assessment: - Mental Status Evaluation: No changes observed - Functional Status Evaluation: No changes observed - Skin Status Evaluation: Laceration Nursing observations, evaluation, and recommendations are: laceration to right side of face noted. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: called no answer voice mail recording/monitor Resident for poor ambulation B. New Testing Orders: - n/a (not applicable/available) C. New Intervention Orders: - first aid/steri strips 2. Behavior note documented by LPN M on 10/15/24 at 12:41 AM. Resident continues to have unsteady gait, laceration to Right side of face. Resident was laying her face on the table when incident occurred, called Dr. no answer, voice mail recording noted. Steri-strips applied, tolerated well. No c/o (complaint of) pain noted. VSS (vital signs stable). 3. Nurse progress note on 10/15/24 at 3:15 PM. Resident was transferred to: (Local hospital) on 10/15/2024 at 3:36 PM. Reason(s) for Transfer: Other -- bradycardia, hypoglycemic. 4. Nurse progress note on 10/15/24 at 3:17 PM. Resident not easily aroused blood sugar 52. Glucagon injection given as ordered. Resident did not consume any of her meals today or fluids. Blood sugar rechecked after 10 min (minutes) 58. Hospice notified. Nurse practitioner notified of resident condition. Blood pressure 111/85, pulse 48, respirations 14. New orders to transfer to emergency room . 5. A review of R105's clinical record revealed no documented assessment of blood pressure, respirations, pulse oximetry, or heart rate between 10/13/24 at approximately 3:30 PM and 10/15/24 at approximately 3:15 PM. 6. Documentation of R105's blood sugars were as follows: 10/13/24 at 5:08 PM 76 mg/dl 10/13/24 at 9:13 PM 136 mg/dl (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/14/24 at 9:56 PM 145 mg/dl 10/15/24 at 12:03 PM 55 mg/dl 10/15/24 at 3:17 PM 52 mg/dl 10/15/24 at 3:19 PM 52 mg/dl 7. Neurological checks to assess R105's mental status, level of consciousness, pupil response, and motor strength were not performed. The DON provided witness statements from LPN M and Certified Nurse Aide (CNA) N. LPN M's witness statement: Resident noted sitting in chair in dinning (sic) room resting her head on the table. Nurse came into the dinning (sic) area and noticed resident bleeding from right side of face. Small laceration with minimal blood noted. Called Dr. No answer, voicemail picked-up. Called family concerning matter, spoke with (R105's Resident Representative) stated Thank you for calling and letting me know. First aid applied (with) butterfly closure strips. Change in Condition (form) completed. Will continue to monitor resident status and inform day shift nurses of incident. Dated 10/15/24. CNA N's witness statement: On Oct. 15, 2024, I (CNA N) came in at 7:00 AM and did round on the 4th floor and seened (sic) that (R105) had blood on her face and went to the MN (midnight nurse, LPN M) nurse and ask (sic) what happen, he said she felt (sic) and he was going out of the door. So we did not have a nurse and she was bleeding so I put butterfly strips on her and when the nurse came I told the nurse that she had a fall. Dated 10/15/24. The DON said a disciplinary action was imposed on LPN M because he should have done more than he did. He did not call me. He did not complete an incident report. R105 should have been monitored every half hour. It is questionable if the injury to (R105's) head was witnessed. LPN M should have started neurochecks on R105 since she hit her face. The DON said the information about R105's injury needed clarification and the investigation continues. The DON could not provide documentation to support that R105 had been monitored and vital signs were assessed between 10/15/24 at 12:41 AM and 10/15/24 at 3:15 PM, with the exception of blood sugar. The DON had no answer regarding why vitals taken on 10/13/24 were included on LPN M's SBAR note of 10/15/24. On 10/29/24 at 5:20 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 34901 This citation pertains to intake MI00146598. Based on observation, interview, and record review, the facility failed to ensure medications for three residents (R113, R115, and R116) located in a treatment cart were not expired. Findings include: It was reported to the State Agency that expired medications were not being discarded. On 10/29/24 at 9:00 AM, the contents of the second-floor treatment cart were observed with Licensed Practical Nurse (LPN) G and revealed the following: - A four-ounce tube of menthol-zinc oxide ointment for R113 expired 9/5/24. - A four-ounce tube of menthol-zinc oxide ointment for R115 expired on 10/27/24. - A four-ounce tube of menthol-zinc oxide ointment for R116 expired on 10/4/24. - A 3.53-ounce tube of diclofenac sodium expired on 3/28/24. LPN G said these medications should have been reordered and the expired medications discarded. On 10/29/24 at 2:45 PM, the Director of Nursing (DON) said the outdated medications should have been discarded. The diclofenac sodium should have been re-ordered. On 10/29/24 at 5:20 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901 This citation pertains to intake MI00146598. Based on observation and interview, the facility failed to provide disposable paper towels, a waste receptacle near a handwashing sink, liners for trash cans, and ensure a shower gurney pad was cleaned and sanitized after use. Findings include: It was reported to the State Agency that supplies were not available, and the facility was dirty and unsanitary. During a tour of the third floor on 10/29/24 starting at 8:20 AM, the following was observed: - A trash can liner had not been placed in the garbage can located in room [ROOM NUMBER] near bed one. Trash was observed inside the garbage can. - The shower gurney pad was soiled and stained. - No paper towels or garbage can were available for the handwashing sink in the shower room. - A trash can liner had not been placed in the garbage can located in the day room. The inside of the trash can was stained with dried liquid along the sides and bottom. During a tour of the second floor on 10/29/24 starting at 9:25 AM, no paper towels were available for the handwashing sink in the shower room. During a return observation of the third floor on 10/29/24 beginning at 12:10 PM the following was observed: - A trash can liner was still not placed in the garbage can in room [ROOM NUMBER] near bed one. - The shower gurney pad remained soiled and stained. Housekeeper J stated the pad was stained and one circular stain looked as if someone laid a cup on it. A stain appeared to be dried liquid about a foot in length. Housekeeper J said another stain was about the size of a quarter and resembled dried liquid supplement. On 10/29/24 at 12:40 PM, Certified Nurse Aide (CNA) K said she has used the shower gurney for a resident on the third floor and added that the gurney pad should be washed and dried after use. On 10/29/24 at 3:10 PM, the Director of Nursing (DON) said every time a person uses the gurney, it should be disinfected after each use. The DON said that trash can should be cleaned, disinfected and have a liner. Paper towels should be available (for hand drying). (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/29/24 at 5:20 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.