

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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
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<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&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>		

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<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 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 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 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>		

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<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>		

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<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>		

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<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>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208</p> <p>Based on interview, and record review, the facility failed to ensure Preadmission Screening (PAS)/Annual Resident (ARR) Mental Illness/ Intellectual Disability/ Related Conditions Identification forms DCH-3877 and/or DCH-3878) documents were reviewed, revised, and sent to the local state agency for review and/or evaluation for intellectual/ developmental disability needs for two residents (R79 and R102) of two residents reviewed for PASSARs, resulting in the potential for unmet intellectual/ developmental disability care needs.</p> <p>Findings include:</p> <p>R102</p> <p>Record review R102's electronic medical record (EMR) revealed admission into the facility on [DATE] with a pertinent diagnosis of major depressive disorder and psychotic disorder with delusions and adjustment disorder. According to the Minimum Data Set (MDS) dated [DATE], R102 had severe impaired cognition and required partial/moderate assistance with most Activities of Daily Living (ADLS).</p> <p>Further review of EMR revealed an annual 3877/78 was completed on 4/18/24 by Social Worker (SW) C. Resident was marked for mental illness and a Level II Screening should have been requested.</p> <p>During an interview on 8/7/24 at 10:59 AM with SW C, it was reported that a Level II screening was never completed. SW C reported that when she contacted the agency that completes the Level II screenings that they had never received a request. When SW C was asked, since the 3877/78 was completed in April of this year, should you have followed up in a timely manner to see if there was a problem, SW C replied, Yes.</p> <p>During an interview on 8/7/24 at 1:18 PM with Nursing Home Administrator (NHA), it was reported that it was the facility's expectation that the Social Worker should follow up when a Level II has not been completed in a timely manner to ensure that there is no delay in services.</p> <p>38271</p> <p>R79</p> <p>On 8/6/24 the medical record for R79 was reviewed and revealed the following: R79 was initially admitted to the facility on [DATE] and had diagnoses including Schizoaffective disorder, depressive type, Delusional disorders, A review of R79's MDS with an ARD of 5/1/24 revealed R79 needed supervision from facility staff with most of their activities of daily living. R79's BIMS score (brief interview for mental status) was 13 indicating intact cognition.</p> <p>A review of R79's most recent PASARR (pre admission screening/annual resident review) in the medical record was observed to be dated for 4/8/22 and indicated R79 had diagnoses of mental illness and was receiving treatment for mental illness and had stated the following: [R79] has a diagnosis of schizoaffective disorder depressive type, delusional disorder, personality disorder, and anxiety disorder.</p> <p>(continued on next page)</p>

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of R79's medical record did not reveal any updated ARR (form 3877) since the one noted in the record that was dated for 4/8/22.</p> <p>On 8/7/24 during a conversation with Social Worker C (SW C), SW C was queried regarding the lack of an updated ARR (form-3877) in R79's record. They reported that the previous Social Worker in the facility should have updated the form and sent it into the local Community Mental Health Services Program (CMHSP) to ascertain if R79 needed a level two OBRA (Omnibus Reconciliation Act) assessment. SW C indicated that they just received access to the system in April 2024 and they were working to try to update all the outstanding assessments. SW C indicated they had not yet reviewed R79 but would would work on getting it updated appropriately.</p> <p>On 8/8/24 a facility document titled Resident Assessment-Coordination with PASARR Program was reviewed and revealed the following: Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines: 1. All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening. a. PASARR Level I- initial pre-screening that is completed prior to admission i. Negative Level I Screen - permits admission to proceed and ends the PASARR process unless possible serious mental disorder or intellectual disability arises later. ii. Positive Level I Screen - necessitates a PASARR Level II evaluation prior to admission. b. PASARR Level II - a comprehensive evaluation by the appropriate state-designated authority (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. 2. The facility will only admit individuals with a mental disorder or intellectual disability who the State mental health or intellectual disability authority has determined as appropriate for admission. 3. A record of the pre-screening shall be maintained in the resident's medical record. 4. Exceptions to the preadmission screening program include those individuals who: a. Are readmitted directly from a hospital.</p> <p>b. Are admitted directly from a hospital, requires nursing facility services for the condition for which the individual received care in the hospital, and has been certified by the attending physician before admission that the individual is likely to require less than 30 days of nursing facility services.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. If a resident who was not screened due to an exception above and the resident remains in the facility longer than 30 days: a. The facility must screen the individual using the State's Level I screening process and refer any resident who has or may have MD, or a related condition to the appropriate state designated authority for Level II PASARR evaluation and determination. b. The Level II resident review must be completed within 40 calendar days of admission. 6. The Social Services Director shall be responsible for keeping track of each resident's PASARR screening status and referring to the appropriate authority. 7. Recommendations, such as any specialized services, from a PASARR level II determination and/or PASARR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. 8. Any level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis).</p> <p>b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. A resident transferred, admitted, or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment.</p>		

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349</p> <p>Based on observation, interview, and record review the facility failed to follow professional standards of practice for medication administration for two (R101 and R44) of four residents reviewed for medication administration resulting in 1) R101's medications left unattended on the breakfast tray and extended/delayed release medications being crushed without an order and 2) R44's medications being unavailable for administration.</p> <p>Findings include:</p> <p>R101:</p> <p>On 8/6/24 at 9:48 AM, R101 was observed seated upright in his bed eating breakfast independently. A medication cup with 9 whole pills was resting on the breakfast tray next to his plate. R101 was unable to be meaningfully interviewed about the medications due to impaired cognition status. Registered Nurse (RN) G came into the resident's room and was asked about the medications on the resident's breakfast tray. RN G said, Oh he takes them himself, but I need to crush them first. RN G took the medication cup off the table, went to the medication cart and proceeded to crush the pills. RN G was asked about crushing a resident's medications and replied, There is no order to crush the meds, but it is easier for him (R101) to take them that way.</p> <p>Review of R101's Electronic Health Record (EHR) revealed the resident had multiple diagnoses that included major depressive disorder and schizoaffective disorder. The Minimum Data Set (MDS) dated [DATE] indicated the resident had severely impaired cognition and required a one person assist with eating. There were no physician's orders to crush the medications. The Medication Administration Record (MAR) had no documentation to indicate the medications were able to be crushed. Further review of R101's MAR revealed that 2 of the 9 medications should not have been crushed due to the medications being extended or delayed release (Divalproex 500 mg delayed release, and Isosorbide 30 mg ER extended release once a day).</p> <p>According to the Mayo Clinic and the manufacturer's guidelines for Divalproex delayed release and Isosorbide extended release the pills should be swallowed whole. Do not split, crush, or chew them. Doing so can release all the drug at once, increasing the risk of side effects.</p> <p>During an interview with the Director of Nursing (DON) on 8/7/24 at approximately 12:00 PM the DON confirmed that medications should not have been left at the bedside unattended for R101. The DON went on to say that medications can only be crushed if there is a physician's order for it.</p> <p>According to the facility's Resident's Self-Administration of Medication policy last revised on 6/2023 in part reads; 3. No medication shall be left unattended without the resident's knowledge that it has been left there for them.</p> <p>According to the facility's Medication Administration - General Guidelines (undated) in part reads; 5. Tablet Splitting: Splitting of tablets should be avoided, and every attempt should be made to obtain an alternative dosage form, medication, or dosing schedule to avoid splitting</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>a. Assure the tablet is appropriate to be split. No sustained-release, enteric coated, or unscored tablets should be split. Determining if a tablet can be safely and appropriately split should be based on an official reference list or by contacting OneCare Pharmacy.</p> <p>6. Tablet Crushing/Capsule Opening: Crushing tablets may require a physician's order per facility policy.</p> <p>a. The instructions for crushing medications should be included on the resident's orders and on the Medication Administration Record.</p> <p>38271</p> <p>R44</p> <p>On 8/6/24 the medical record for R44 was reviewed and revealed the following: R44 was initially admitted to the facility on [DATE] and had diagnoses including Gastroesophageal reflux disease and Hypertension. A review of R44's MDS with an ARD of 6/3/24 revealed R44 was independent with most of their activities of daily living. R44's BIMS (brief interview for mental status) score was nine indicating moderately impaired cognition.</p> <p>A review of R44's Physician orders revealed the following: Fluticasone Propionate Suspension 50 MCG/ACT 1 spray in each nostril one time a day for allergic rhinitis (AR). Start date-4/4/24.</p> <p>Claritin Oral Tablet 10 MG (Loratadine) Give 1 tablet by mouth one time a day for AR (Allergic rhinitis).-Start Date-02/14/2024</p> <p>A review of R44's medication administration record (MAR) for July and August 2024 revealed the following dates in which R44 was not administered their Fluticasone spray: 7/5, 7/9, 7/29, 8/5, and 8/6.</p> <p>A review of R44's MAR for July and August 2024 revealed the following dates in which R44 was not administered their Claritin: 7/5, 7/9, 7/19, 8/5 and 8/6.</p> <p>On 8/7/24 at approximately 2:13 p.m., Nurse S was queried regarding the availability of R44's fluticasone and they were observed looking though the medication cart and indicated R44 did not have any fluticasone in the cart. Nurse S reported that it would have to be reordered. Nurse S was queried if they administered it to R44 that morning and they indicated they did not because they did not have any in the cart.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/7/24 at approximately 2:20 p.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the process of reordering medication if it is not available. The DON reported if the Nurses went to administer the medication and there was none available, they would have to call the pharmacy and can have it delivered on the next shipment and call the Physician. The DON was queried why their were so many missed administrations in R44's MAR and they indicated that it was a standard of practice to reorder it after the first missed dose and that they would have to check the supply closet to see if any had been delivered and that they had to educate the facility Nursing staff on the proper procedures. The DON was queried regarding R44's claritin not being administered on 8/5 and 8/6 and they reported that it was a stock medication and they had it on other floors and the Nurses were supposed to go get it to administer instead of not administering and documenting that it was unavailable.</p> <p>On 8/8/24 a facility document titled Medication Administration-General Guidelines was reviewed and revealed the following: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions .C. Documentation-1) The nurse who administers the medication records the administration on the resident's MAR immediately after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the nurse who administered the medications report off-duty without first recording the administration of all medications</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper weight monitoring occurred for two residents (R27 and R71) deemed to be at nutrition risk out of six residents reviewed for nutrition status, resulting in weight changes to go undetected and potentially compromise nutrition status.</p> <p>Findings include:</p> <p>R27:</p> <p>On 8/6/24 at approximaely1:30 PM R27 was observed in her bed with her eyes opened and music playing on her radio. The resident could not be meaningfully interviewed due to severe cognition impairment. The resident had an IV pole with a tube feeding pump attached. No tube feeding was present on the IV pole. Registered Nurse (RN) C was asked if R27 received tube feedings and replied, Yes, she gets them over night. The feeding goes up at 5:00 PM and is usually completed by 7:00 AM.</p> <p>According to R27's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with history of a stroke, dysphagia (inability to swallow effectively), and dementia. On 3/6/24 a significant change Minimum Data Set (MDS) was completed for weight loss. The MDS indicated the resident had severe cognition impairment, was not verbal, and totally dependent on staff for all activities of daily living. R27 had a feeding tube (flexible tube inserted through the abdominal wall to administer liquid nourishment, fluids, and medications). On 3/11/24, the physician ordered Jevity 1.5 tube feeding at 70 milliliters (ml) an hour to run for a total of 1120 ml to provide 1680 kcalories per day. On 7/23/24 a progress note written by Registered Dietitian (RD) F indicated the resident's weight had not been documented since 5/28/24. A review of R27's weights revealed the last documented weight was on 5/28/24 and recorded as: 133 lbs. (pounds).</p> <p>On 8/7/24 at 2:53 PM RD F was asked how often residents who receive tube feeding should be weighed. RD F said, At least monthly if they are stable. The resident triggered for significant weight loss in March, so probably weekly until the weights are stable. RD F could not say if the resident's weights had been stabilized. RD F said, There is difficulty obtaining accurate weights at times. I don't do them, the CNAs (Certified Nursing Assistants) do the weights.</p> <p>On 8/8/24 at 1:28 PM the nurse unit manager, Licensed Practical Nurse (LPN) I was asked about the R27's weights and replied. She (R27) was weighed on 8/5/24 and was at 133 lbs. I just forgot to record it. At this time LPN I provided a handwritten weight record that indicated R27's weight on 8/5/24 was 133.0 lbs. LPN I was asked to weigh the resident for accuracy.</p> <p>On 8/8/24 at 2:00 PM the Director of Nursing (DON) reported that R27's weight was observed to be at 147.4 lbs. The DON could not explain the 14.4 lbs. weight difference in 3 days time.</p> <p>R71:</p> <p>On 8/06/24 at 10:54 AM R71 was observed ambulating in the hallway with missing and decayed teeth. R71 was unable to be interviewed due to cognition impairment.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the Electronic Health Record (EHR) R71 admitted to the facility with Medicaid benefits on 7/11/23 with diagnoses that included schizophrenia and alcohol abuse. The Minimum Data Set (MDS) dated [DATE] identified R71 to have severely impaired cognition with a Brief Interview Mental Status (BIMS) score of 5/15. On 7/15/24 a progress note written by RD F read as follows: RD requesting a re-weigh. The weight records indicate a 20 lb. weight loss in three weeks time.</p> <p>R71's recorded weights were as follows:</p> <p>5/23/24: 144.0 lbs.</p> <p>6/9/24: 144.0 lbs.</p> <p>6/23/24: 144.0 lbs</p> <p>7/12/24: 124.0 lbs - (20 lb change)</p> <p>8/6/24: 124.8 lbs.</p> <p>According to R71's nutrition care plan interventions initiated on 7/17/2023 included the following; report any significant weight changes to my physiciain.</p> <p>08/06/24 at 3:55 PM RD F was asked about R71's significant weight change on 7/12/24. RD F said she really could not explain it but would get a re-weigh.</p> <p>On 8/6/24 a progress note written by RD F indicates the weight of 124.8 is accurate and the resident does not appear to have lost such a significant amount of weight. RD recommended Ready Care 2.0 (a nutritional supplement) once a day and that RD will monitor the next weight.</p> <p>On 8/7/24 at 3:32 PM during an interview with the Director of Nursing (DON) she said that R27 had lost some weight but doubted that it was over a short period of time. The DON said that it is possible the CNA's may not be weighing residents accurately.</p> <p>According to the facility's Weight Monitoring policy last revised 1/2021 in part reads;</p> <p>Based on the resident ' s comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range</p> <p>Compliance Guidelines:</p> <p>Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem.</p> <p>5. Weight will be obtained upon admission, readmission and weekly for the first four weeks after admission and at least monthly unless ordered by the physician.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>6. Weight Analysis: The newly recorded resident weight should be compared to the previous recorded weight to determine if a re-weight is necessary.</p> <p>7. A significant change in weight is defined as:</p> <ul style="list-style-type: none"> a. 5% change in weight in 1 month (30 days) b. 7.5% change in weight in 3 months (90 days) c. 10% change in weight in 6 months (180 days).

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349</p> <p>Based on observation, interview, and record review the facility failed to remove a feeding tube (flexible tube inserted through the abdominal wall to administer liquid nourishment, fluids, and medications) when there was no longer a valid clinical indication for its use in one (R29) of two residents reviewed for feeding tubes resulting in R29 expressing feelings of frustration with the presence of an unused feeding tube along with swelling, redness, and drainage at the insertion site, and leakage through two visible holes/cracks in the tube itself.</p> <p>Findings include:</p> <p>On 8/06/24 at 9:44 AM R29 was observed standing in the doorway of his room with yellow colored drainage on the front of his shirt approximately 4 inches in diameter. Upon interview R29 lifted up his shirt to expose a feeding tube with a saturated dressing around it with yellowish-green and rusty colored drainage. The feeding tube was approximately 1 foot long, hanging loosely without any securement device and tucked down into the resident's pants. R29 said, I want this out! I can't go back home with this. It is wet and leaks. The resident's briefs had several small rusty colored stains. Upon closer inspection the feeding tube had two visible holes/cracks with rusty colored liquid leaking out through the holes. R29 said, Yeah, it has holes in it and leaks out on my clothes. At this time Registered Nurse (RN) C was asked about the resident's feeding tube. RN C said, Yeah, we know its infected. We have wound care looking at it. I have been advocating for the doctor to take this tube out, but the doctor said 'no'. He (R29) has been eating and drinking double portions, takes his medications by mouth, and had gained weight, so I don't know why he (the doctor) won't remove it. RN C removed the saturated dressing around R29's feeding tube. The insertion site was red and swollen with creamy drainage at the insertion site. RN C flushed the feeding tube with water and creamy drainage came out through the insertion site and through two holes/cracks in the tube. RN C moved the clamp of the tube closer to the resident's body to prevent gastric contents from leaking out through the feeding tube. RN C said she would contact the doctor about the resident's feeding tube leaking. R29 then said, I change the dressing myself because it drains a lot. The nurses showed me how to do it and give me the supplies.</p> <p>On 8/6/24 at approximately 12:40 PM R29 was observed in the dining room eating a regular diet of chicken, carrots, and salad. The resident consumed 90% of the lunch meal.</p> <p>On 8/07/24 at 9:50 AM R29 was observed standing in the doorway of his room awaiting his medications. The resident lifted up his shirt to reveal the feeding tube hanging loosely, no securement device and no dressing on it. A small amount of serosanguinous fluid (light pink in color consisting of serous fluid and blood) was draining from around the feeding tube's insertion site onto this abdomen. R29 said, I'm going to the meeting today at 10:00, so I need my meds now.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/07/24 at 9:56 AM RN C administered R29 his medications. R29 swallowed whole pills with a full glass of water without difficulty. Immediately after drinking the water the resident's feeding tube was observed leaking clear liquid through the two holes in the tube onto the resident's pants. RN C moved the clamp of the tube closer to the resident's body to prevent the drainage. RN C said the physician did not return her call from yesterday, and she will call him today about the resident's feeding tube.</p> <p>O 8/7/24 at 11:30 AM during an interview with the Director of Nursing (DON) she said she spoke with R29's physician and he wanted to keep the feeding tube in place because the resident may start losing weight again. The DON said, The resident wants the feeding tube removed because he thinks having it (the feeding tube) is restricting him from transferring back to his group home. I told the doctor this and he still wants to keep the feeding tube. The DON was asked why the feeding tube was not changed when there was signs of infection at the insertion site and two holes in the tube. The DON said she would contact the physician again.</p> <p>On 8/7/24 at 12:30 PM R29 was observed in the dining room eating his regular diet lunch meal without difficulty. R29 ate 100% of his lunch meal.</p> <p>On 8/8/24 at 10:31 AM R29 was observed in his room seated on his bed. The resident's shirt was lifted up exposing the resident's feeding tube. The feeding tube was tied in single knot. Upon inquiry the resident said he did it (tied it in a knot) to prevent drainage coming out through the holes onto his clothes. R29 said he was going on a field trip to [NAME] in a couple days and was mad because the doctor would not take the tube out before then. R29 said, I'm eating good and taking my meds. Why can't they take this out?</p> <p>On 8/8/24 at 10:32 AM the DON was asked to observe R29's feeding tube. The DON said the physician had looked at it yesterday and prescribed triple antibiotic ointment to be placed around the insertion site but did not want to remove the tube. The DON was unaware the resident had tied the tube in a knot. At approximately 1:30 PM the DON said the resident was sent out to the emergency room (ER) hospital to have the feeding tube removed but they (the ER) did not remove it. The DON could not explain why the staff or physician could not remove the feeding tube at the facility.</p> <p>According to the Electronic Health Record (EHR) R29 readmitted to the facility on [DATE] with multiple diagnoses that included developmental disorder of scholastic skill, anxiety disorder, schizoaffective disorder, and unspecified protein calorie malnutrition. R29 is identified to have moderate cognition impairment and be independent with eating, mobility, and hygiene. On 5/24/24 a nutritional assessment indicated R29 had triggered for significant weight loss and a feeding tube placed on 5/15/24. The resident was prescribed a general diet with double portions and supplements. The nutritional assessment included the following documentation: The resident is improving and is unhappy with the feeding tube placement and often refuses tube feeding to be run. On 7/6/24 the physician consulted wound care for the feeding tube site due to signs of infection around the insertion site. On 7/12/24 solosite wound gel was ordered to the feeding tubes insertion site every day (Solosite is used to promote wound healing of surgical incisions and venous ulcers). On 7/14/24 a dietary note documented the following: The resident continues to eat 100% of his meal and is asking for double portions and eating snacks. Resident expresses that he is full after dinner and refuses the tube feeding. I have informed the doctor of the need to reevaluate the resident's nutritional needs. On 7/24/24 a progress note documented; resident is eating more than needed to meet caloric needs. Registered Dietitian recommends to discontinue the health shakes.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nutritional care plan revised on 7/24/24 included the following documentation; the resident frequently stated the food is cold and nasty. The resident had shown a weight loss and refused to eat and not allow staff to run tube feeding. However the resident started to eat very well and the tube feeding was discontinued. Weights have improved. According to the nutritional assessment the resident's goal weight and ideal body weight range was 149-180 pounds. On 8/8/24 R29's weight was recorded as 149.8 pounds.</p> <p>On 8/13/24 at 3:30 PM R29's Legal Guardian was interviewed regarding the feeding tube and said, The DON called me on August 8th to tell me they sent the resident out to the ER to remove the feeding tube and the hospital did not remove it. I don't understand why they didn't take it out at the facility. I encouraged them to take it (feeding tube) out several times before. I was told he was eating and had gained weight. I don't know why they would keep it in. I was also told he needed antibiotic cream around it because it was infected now. I'm going to call them back and find out why he (R29) even still needs it (the feeding tube). Its just a source of infection now. If he needs it again they can replace it then.</p> <p>According to the facility's policy for Care and Treatment of Feeding Tubes last revised on 6/2023 in part; It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.</p> <p>Policy Explanation and Compliance Guidelines:</p> <ol style="list-style-type: none"> 1. Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush 5. The feeding tube will be secured externally. <p>2. Replacement of gastrostomy tube:</p> <ol style="list-style-type: none"> a. Only a simple gastrostomy tube may be replaced in the building. PEG tubes cannot be replaced in the building. PEG specifically describes a long G-tube placed by endoscopy, and stands for percutaneous endoscopic gastrostomy b. Once it is noted that the resident ' s G-tube is no longer in place, replacement should occur as soon as possible to prevent tract narrowing and closure. c. Only a nurse trained in Gastronomy tube replacement may replace a G tube. A physician ' s order is required for the nurse to replace the G-tube in the facility. The order must include the size of the G-tube and the balloon. The G-tube may be replaced by either an LPN or an RN, but it must be the RN or physician/extender to educate this nurse and ensure competency. d. Follow the manufacturer ' s recommendations for proper procedure to insert the G-tube. e. If G-tube replacement does not occur easily, abort the procedure, and contact the primary physician <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>9. The facility will notify and involve the physician or designated practitioner of any complications, and in evaluating and managing care to address the complications and risk factors.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>22349</p> <p>Based on observation, interview, and record review, the facility failed to ensure a medication administration error rate of less than five percent, with 13 errors identified out of 35 opportunities, affecting two residents (R73 and R29) of four residents observed for medication administration, resulting in a medication error rate of 37.1%.</p> <p>Findings include:</p> <p>R73:</p> <p>On 8/7/24 at 9:05 AM during observation of medication administration Registered Nurse (RN) C could not use the computer on the medication cart to view the resident's Medication Administration Record (MAR) . RN C used the computer at the nurse's station to access the resident's MAR, wrote R73's medications on a sheet of paper and proceeded to administer medications to the resident by using the paper. The following medication errors were observed:</p> <p>#1) Administered pantoprazole 40 mg (milligram) 1 caplet.</p> <p>Order was for Pantoprazole Sodium 40 mg tablet once a day. Scheduled for 6:00 AM. According to the Medication Administration Record (MAR) the resident received pantoprazole 40 mg at 6:00 AM, the next dose was not due at the 8/8/24 at 6:00 AM.</p> <p>#2) Administered Fish Oil 500 mg 1 capsule.</p> <p>Order was for Fish Oil 1000 mg 1 capsule one time a day.</p> <p>#3) Administered Brimonidine Tartrate Ophthalmic Solution 0.2% 1 drop was placed in each eye.</p> <p>Order was for Brimonidine Tartrate Ophthalmic Solution 0.2% 1 drop in left eye only every 12 hours.</p> <p>#4) Administered Prednisolone Acetate Ophthalmic suspension 0.1%, 1 drop was placed in each eye.</p> <p>Order was for Prednisolone Acetate Ophthalmic suspension 0.1% drop in right eye only, four times a day.</p> <p>#5) Administered Maxitrol (Neomycin-Polymyxin Dexamethasone) ointment 3.5-10,000-0.1 % in left eye.</p> <p>There was no current order for this medication.</p> <p>#6) Albuterol Sulfate Aerosol Powder Breath activated inhaler - 1 puff was self-administered.</p> <p>Order was for Albuterol Sulfate Aerosol Powder Breath activated inhaler -2 puffs inhaled orally every 4 hours as needed for Shortness of Breath.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/7/24 at approximately 12:30 PM the Director of Nursing (DON) was asked about RN C not using the computer on the medication cart to administer medications to R73. The DON said the MARs are printed out and placed on the bottom drawer of the medication carts every morning as a back up if the wi-fi or computers go down. The DON said there was no electronic problems and could not understand why RN C could was unable tot use the computer on the medication cart. The DON said the nurse should have contacted the unit manager before trying to administer medications from memory or writing it on a piece of paper. The DON said if a nurse receives a verbal order from a physician the expectation is that order should be processed immediately.</p> <p>According to the facility's Medication Administration policy (undated) in part :</p> <p>Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility ' s medication distribution system. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions.</p> <p>Procedures .</p> <p>3. The Five Rights (Right Resident, Right Drug, Right Dose, Right Route, and Right Time) are applied for each medication being administered. A triple check of these Five Rights is recommended at three steps in the process of preparation of a medication for administration:</p> <p>a. When the medication is selected, the label, container, and contents are checked for integrity and compared against the Medication Administration Record (MAR) by reviewing the Five Rights.</p> <p>b. When the dose is removed from the container, it is verified against the label and the MAR by reviewing the Five Rights.</p> <p>c. Immediately after the dose is prepared and the medication is put away, the label is reverified against the MAR by reviewing the Five Rights.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271</p> <p>Based on interview and record review the facility failed to ensure a Physician ordered laboratory (lab) diagnostic was completed for one resident (R48) of one residents reviewed for diagnostics.</p> <p>Findings include:</p> <p>On 8/6/24 the medical record for R48 was reviewed and revealed the following: R48 was initially admitted to the facility on [DATE] and had diagnoses including Paraplegia and Multiple sclerosis. A review of R48's MDS (minimum data set) with an ARD (assessment reference date) of 5/15/24 revealed R48 needed supervision from facility staff with personal hygiene. R48's BIMS (brief interview for mental status) score was 15 indicating intact cognition.</p> <p>A Physician's order dated 3/5/24 revealed the following: order cbc (complete blood count), cmp (comprehensive metabolic panel), tsh (thyroid stimulating hormone), A1C (average blood glucose level), vit D (vitamin D), vit B12 and lipids one time a day every 3 month(s) starting on the 1st for 7 day(s) for Hypertension. Start Date 4-1-24.</p> <p>Further review of the medical record did not reveal the ordered diagnostic results for (June-July 2024) ordered labs.</p> <p>On 8/07/24 at approximately 12:39 p.m., during a conversation with the Director of Nursing (DON), the DON was queried for the ordered labs that were not available in the chart and ordered to be done every three months starting on 4/1/24. The DON indicated they would have to look for the results.</p> <p>On 8/7/24 at approximately 2:20 p.m., during a follow up conversation with the DON, the DON indicated they did not have the lab results for the June-July 2024 routine labs that were ordered on 3/5/24. They indicated they had the lab results from March 2024 but the follow up labs were not completed due to an issue with the current laboratory not receiving the order. The DON reported the labs would be rewritten that day and followed up on for completion.</p> <p>On 8/8/24 a facility document titled Laboratory, Radiology, and other Diagnostic Services was reviewed and revealed the following: Policy: The facility will provide laboratory and radiology services when ordered in accordance with state law. Policy Explanation and Compliance Guidelines: 1. The facility will provide or obtain laboratory, radiology or other diagnostic services to meet the needs of its residents. 2. The facility is responsible for the timeliness of the services. 3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the requirements. 4. Assist the resident in making transportation arrangements to and from the services if necessary. 5. All laboratory and diagnostic reports will be dated and contain the name of the testing location and will be filed in the resident's clinical record. 6. Staff will notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside the clinical reference range, or as ordered.</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349</p> <p>Based on observation, interview, and record review the facility failed to schedule a physician ordered dental appointment for one of one resident (R71) reviewed for dental services resulting in R71 not being seen by a dentist and potential for dental care needs to go unmet.</p> <p>Findings include:</p> <p>On 8/06/24 at 10:54 AM R71 was observed ambulating in the hallway with missing and decayed teeth. R71 was unable to be interviewed due to cognition impairment.</p> <p>According to the Electronic Health Record (EHR) R71 admitted to the facility with Medicaid benefits on 7/11/23 with diagnoses that included schizophrenia and alcohol abuse. The Minimum Data Set (MDS) dated [DATE] identified R71 to have severely impaired cognition with a Brief Interview Mental Status (BIMS) score of 5/15. On 5/22/24 the Physician ordered for the resident to have dentist evaluation for left jaw swelling. There was no documentation to support R71 had seen a dentist. R71 had a valid court-appointed Legal Guardian (LG) with current contact information in the EHR.</p> <p>On 8/06/24 at approximately 12:45 PM R71 was observed to independently eat the lunch meal in the dining room without difficulty. There was no visible swelling of the resident's left jaw area.</p> <p>On 8/06/24 at 1:35 PM Social Worker (SW) C was interviewed regarding R71's dental evaluation order. SW C said the dentist had been to the facility on [DATE] and had not seen R71 because the resident's LG had not signed a dental services consent form. SW C reviewed the resident's EHR and acknowledged there was no documentation to indicate R71's LG had been requested to sign a dental services consent form.</p> <p>On 8/8/24 at 11:00 AM R71's LG was interviewed via phone regarding a dental consent. The LG reviewed the resident's notes and said, There is nothing here requesting us to consent for dental services. We would sign that consent immediately if it was needed.</p> <p>According to the facility's Dental Services policy last revised on 6/20/23 in part; It is the policy of this facility, in accordance with resident's needs to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care.</p> <ol style="list-style-type: none"> The dental needs of each resident are identified through the physical assessment and MDS assessment processes and are addressed in each resident ' s plan of care Residents and/or resident representatives, during the admission process, are notified of dental services available under the State plan (i.e. state-run programs), and of the potential charges that may apply in the case of routine or emergency dental care provided by outside resources The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location 		

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<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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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>		

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<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>		

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<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>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208</p> <p>Based on observation, interview, and record review the facility failed to ensure that personal protective equipment (PPE) was worn while performing wound care for one resident (R104) out of one resident observed during wound care.</p> <p>Findings Include:</p> <p>During an observation of wound care on 8/7/24 at 10:30 AM, Registered Nurse (RN) B entered R104's room to perform wound care for a Stage III pressure ulcer (wound with full thickness skin loss) on resident's buttock , no PPE was applied by RN B or the staff assisting with treatment. R104's door had signage warning of enhanced barrier precautions.</p> <p>Record review revealed R104 was admitted into the facility on [DATE] with a pertinent diagnosis of Pressure Ulcer (bedsore) to right buttock. According to the Minimum Data Set (MDS) dated [DATE], R104 had impaired cognition and was dependent on most Activities of Daily Living (ADLS).</p> <p>Record review of R104's Kardex (care instructions) dated 8/7/24 it was documented, .Enhanced Barrier Precautions: Gown/Gloves should be worn during high-contact resident care activities (Dressing, Bathing, Transferring, Hygiene, Linen changes, Toileting/Brief changes, device or wound care).</p> <p>During an interview on 8/7/24 at 1:30 PM with Director of Nursing (DON), it was reported that the staff should follow the guidelines for enhanced barrier precautions, and wear PPE when performing high contact activities, such as wound care.</p> <p>During an interview on 8/8/24 at 10:45 AM with Infection Control Preventionist (IFC) A, it was reported that while performing wound care nursing staff should wear PPE.</p> <p>Record review of facility policy Enhanced Barrier Precautions last revised 3/2024 documented, . Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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>		

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<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>		

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<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>		