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	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation and interview the facility failed to properly dispose of refuge and maintain cleanliness of the garbage and dumpster area, resulting in the potential harborage of pests. This deficient practice has the potential to affect all 109 residents in the facility. Findings include:On 8/19/25 at 8:30 A.M., at 10:30 A.M. and at 4:27 P.M. two of the facility's dumpsters were observed with open lids and overflowing garbage, broken and/or furniture and boxes. The surrounding grounds were littered with food particles that had been dropped or fell from the garbage bags by squirrels and birds. Occasionally birds were noted pecking holes in the garbage bags exposing the contents of the garbage to gnats and flies. Near the dumpster area and adjacent hall and back door to the kitchen were observed with flies.On 8/19/25 at approximately 9:00 A.M. Dietary manager F was interviewed concerning the dumpster area. Manager F indicated the maintenance department was responsible for cleaning the area and confirmed garbage was collected on Mondays and Wednesdays weekly.On 8/20/25 at 4:16 P.M., the surrounding grounds were swept but the garbage lids remained open. Periodically rain showers soaked the boxes and the garbage contents contributing to an environment for other unwanted pests and odors.On 8/25/25 at 10:30 A.M. Maintenance Director J confirmed the days of garbage collection and reported the facility had been in the process of renovation and replacing furniture and the opened dumpsters and food debis created an environment for pests to hide and harbor.

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide privacy for one resident (R3) of two residents reviewed for privacy resulting in the resident being exposed during wound care On 8/21/2025 at 11:30 AM, Registered Nurse (RN) S and Certified Nurse Assistant (CNA) R was observed providing wound care to R3's sacrum/coccyx (buttocks) area. RN S did not draw the curtain around R3's bed or close R3's room door which allowed visualization of the R3's exposed body from the hallway.Record review revealed that R3 was initially admitted on [DATE]. R3 had the following diagnosis: type 2 diabetes, COPD, hypertension, generalized anxiety, bipolar disorder, and suicidal ideations.Record review of R3 quarterly Minimum Data Set (MDS) from 7/7/2025 for a Brief Interview for Mental Status (BIMS) revealed R3 was cognitively intact with a score of 15 out of 15.On 8/21/2025 at 11:45 AM, CNA R was interviewed and confirmed the door was left open while R3 was receiving wound care. CNA R said the door should have been closed.On 8/21/2025 at 11:50 AM, RN S was interviewed and acknowledged the door was left open during wound care. RN S said the door should have been closed during the procedure.On 8/21/2025 at 2:40 PM, the Director of Nursing (DON) was queried and interviewed about R3's wound care. The DON said the privacy curtain should have been completely drawn around R3's bed and the door should have been closed during wound care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide a bed that was appropriate and in good condition for one (R66) of three residents reviewed for reasonable accommodations, resulting in unmet comfort needs. Findings include:On 8/19/2025 at 12:16 p.m. R66 was observed sitting in an upright position in a standard hospital bed (6.6 feet), watching television. R66 is non-verbal with severe cognitive impairment and was unable to participate in the resident interview. R66 was also observed with feet hanging off the end of the bed. The foot board was off the bed and propped against the wall. R66 was observed to appear taller than the length of the bed. On 8/19/25 at 12:19 p.m., CENA L was queried about the bed size and the disrepair. CENA L said R66 kicked the foot board off and is getting a new bigger bed. CENA L also said the bed had been in disrepair for a couple of weeks. The nurse's aide was uncertain of the bed's order status. Review of the clinical record documented R66 was admitted into the facility on 6/10/25 with diagnoses that included schizophrenia, dementia, unspecified severity, with other behavioral disturbance, antisocial personality disorder, myopia, bilateral, candidiasis, and pressure ulcer of left upper back, stage 3. According to the admission Minimum Data Set assessment dated [DATE], R66 had severe cognitive impairment and was dependent on all activities of daily care. The assessment also documented R66's admission height as 72 inches (6 feet) tall. On 8/21/25 at 11:45 p.m. LPN Q was queried about R66's requiring a new bed. LPN Q said nurses round every two hours, however, was not aware of the resident needing a new bed. LPN Q was queried about what nurse rounds consist of. LPN Q stated, We focus on clinical concerns when we do rounds. LPN Q was asked would a resident requiring a new bed be considered a clinical concern. LPN Q did not respond. On 8/21 25 at 1:15 p.m. Assistant Director of Nursing (ADON) P was queried about R66 needing a new bed and its order status. ADON P said the bed was ordered and waiting for maintenance to take to the resident's room. ADON P presented the Work Order from the medical equipment company dated 8/7/25. The invoice documented the new bed (bariatric 42 inches) was delivered to the facility on 8/11/25. ADON P was queried about the length of the bed and broken foot board. ADON P said an extender was ordered today (8/21/25). ADON P was unable to give an explanation why the extender was not ordered at the same time of the mattress or the delay in providing R66 with an appropriately sized bed. On 8/21/25 at 12:00 p.m. the Director of Nursing (DON) was interviewed. The DON said they were new to the facility (one week) and were not aware of the residents' needs, however, was told the mattress had been ordered and waiting for maintenance to replace the mattress. The DON said they were unaware the bed was broken. On 8/25/25 at 1:22 p.m. Maintenance Director J was interviewed about R66's bed needing to be replaced. Maintenance Director J said they were not aware the mattress was delivered to the facility and was under the assumption R66 required a new frame not an extender or new mattress. Review of the facility's policy titled Accommodation of Needs dated 12/24 documented in part the following: The facility will make reasonable accommodations to individualize the resident's physical environment including their personal bathroom and bedroom and the common living areas within the facility. Facility staff shall make efforts to reasonably accommodate the needs and preferences of the resident as they make use of their physical environment.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one resident room (R62) of nine residents was in good repair.R62.On 8/25/2025 at 11:23 a.m., R62's room was noted with a loud unpleasant odor. Observed chipped paint and holes in the wall over the bed and a fan hanging near the bed with thick dust particles blowing from the fan. The bathroom was observed with multiple areas of black residue on the wall and behind the toilet. The vent was covered with thick dust particles, holes in the wall near the tissue holder and brown stains and scuff marks on the bathroom door.On 8/25/2025 at approximately 11:30 a.m. during an interview R62 stated, The bathroom is filthy and uncomfortable. I have no control over it. I have to wait until they get to it, I guess. R62 confirmed the facility was aware of the repairs and cleaning needed for a long time.On 8/25/2025 at 11:55 a.m., Maintenance Director (MD) J was asked during an interview in R62's bathroom what was the black areas on the wall? MD J stated, Oh yes, it got worse, but I don't think its mold. I think the black spots are from when we used mud to seal the cracks and holes and it just got black. MD J was asked had any staff member written any repair orders? MD J stated, The staff suppose to report that and document in TELS (a system used for staff to report repair needs) for a work order to be repaired. MD J was asked who was responsible for dusting and cleaning the residents' vents and fans MD J stated, The housekeepers supposed to dust the vents, and fans. The fans and vents should not have been that dusty.On 8/25/2025 at 11:55 a.m. while observing R62's room and bathroom, Regional Director of Operation (RDO) A confirmed R62's bathroom and room needed to be cleaned and in need of repairs. RDO A stated, I have not been here long, but this is something I see needs to be done.According to the electronic health record (EHR), R62 was readmitted into the facility on [DATE] with diagnoses of chronic obstruction pulmonary disease, hypertension, multiple sclerosis, and Parkinsonism. R62's 7/2/32025 quarterly Minimum Data Set (MDS) assessment revealed R62 had intact cognition with a BIMS (brief interview for mental status) score of 15/15.According to the facility's 1/23/2024 Safe and Homelike Environment policy: In accordance with resident ?s rights, the facility will provide a safe, clean, comfortable and homelike environment.Environment refers to any environment in the facility that is frequented by residents, including (but not limited to) the resident's room, bathroom.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow standards of practice for medication administration for one (R91) of three residents when a single-dose medication (eye drop) was unopened and intact at the bedside but signed out on the Medication Administration Record (MAR) as being administered. Findings include: On 8/21/25 at 10:37 AM R91 reported they did not get all of their eye drops today. Upon further inquiry R91 said, They keep saying they ain't got it. I haven't got those eye drops in the white box (Cyclosporine 0.05%) for a couple days now. I don't know what the problem is. A review of R91's MAR revealed Licensed Practical Nurse (LPN) B had documented R91's eye drops (Cyclosporine 0.05%) were 'administered' for the 8/21/25 10:00 AM dose. At 10:40 AM LPN B was interviewed regarding R91's eye drops. LPN B said R91's eye drops (Cyclosporine 0.05%) were not available in the medication cart and therefore not administered. An inspection of the medication cart revealed there were no Cyclosporine 0.05% eye drops for R91. LPN B acknowledged that the Cyclosporine 0.05% eye drops come as individual single-doses in a white box. LPN B confirmed they had documented in the MAR that the eye drops were administered. LPN B then said, Oh, yeah, his (R91's) eye drops are at the bedside. I must have gave them. LPN B went to R91's room and returned to the medication cart with one single-dose eye drop that was unopened and intact. Upon further inquiry LPN B acknowledged that the eye drops could not have been administered if the single-dose package was unopened and therefore should not have been signed out as administered. According to R91's Electronic Health Record (EHR) the resident admitted to the facility with multiple diagnoses that include Chronic Obstructive Pulmonary Disease, Diabetes, and history of fractured ribs and sternum. According to the Minimum Data Set, dated [DATE], R91 had no cognition impairment with a brief interview for mental status score of (BIMS) 15/15. A physician's order on 12/12/2024 prescribed the following eye drops: Cyclosporine emulsion 0.05% eye drops, instill 1 drop in both eyes twice a day for dry eyes due to inflammation. There is no order to allow medications at the bedside. There is no assessment or evaluation for the resident to self-administer medication. A review of the R91's August 2025 MAR indicated that the Cyclosporine 0.05% eye drops were administered everyday as prescribed. A note on 8/15/25 indicated that the pharmacy was requested to refill R91's Cyclosporine 0.05% eye drops. On 8/18/25, a second note indicated that the pharmacy was requested to be refill R91's Cyclosporine 0.05% eye drops. On 8/21/25 at 11:10 AM during an interview with the Nursing Home Administrator (NHA) they said it is a standard of practice that the nurse does not sign out a medication until after it is given. According to the facility's Medication Administration- General Guidelines (undated); 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. C. Documentation1) 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.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents (R63 and R77) shaves and hair care out of two residents reviewed for Activities of Daily Living (ADLs), resulting in unmet ADL needs. R63On 8/19/2025 at approximately 12:37 p.m., R63 was observed sitting in bed with unkempt hair. During an interview R63 reported not receiving assistance with hair care. R63 was asked to recall when hair care was last offered and provided by the staff. R63 stated, Oh, my God, it's been a long time. No one offers to comb my hair. I watch my roommate's hair get combed and not [NAME]. My hair needs to be combed because I have had these braids for a long time. My hair has not been combed, brushed or braided since my Birthday (approximately three months ago). I went out for my birthday on that day. Sometimes I get embarrassed because my hair is not combed. I would like for my hair to be combed or braided. According to the Electronic Health Record (EHR) R63 was initially admitted into the facility on 7/2/24 with diagnoses of asthma, hemiplegia unspecified (Hemiplegia is the total paralysis of one side of the body, affecting the arm, leg, and sometimes the face on the same side) and anemia. According to the admission Minimum Data Set assessment dated [DATE], R63's cognition was moderately impaired with a BIMS (brief interview for mental status) score of 08/15 and required one-person assistance with grooming/hygiene. Review of the 7/9/2024 ADL Care Plan documented, I have an ADL self-care performance deficit related to history of cerebral infarction (stroke) with hemiplegia, Diabetes Mellitus, non-ambulatory, wheelchair for locomotion. Interventions as follows:-Dressing: I require 1 staff participation to dress.-Person hygiene: I require 1 staff participation with personal hygiene and oral care.-Bathing: I need 1 person assistance to bathe.There was no documentation for refusal. On 8/25/2025 at 11:23 a.m. Licensed Practical Nurse (LPN) K was asked what were the daily duties of the Certified Nursing Assistance (CNA) when assisting residents with care. LPN K said the CNAs are to do ADL care like shaves, nail care, wash and comb their hair, moisturize the skin. R77.On 8/19/2025 at approximately 12:04 p.m. R77 was observed lying in bed with long, untrimmed, dirty fingernails and both feet with long, thick, untrimmed, discolored toenails. During an interview R77 reported not receiving assistance with fingernails and toenail care. R77 stated, They won't clean and cut my fingernails and toenails. I want my fingernails and toenails cut and cleaned. On 8/19/2025 at approximately 12:15 p.m., Licensed Practical Nurse (LPN) I was interviewed regarding providing residents with ADL care. LPN I said the nurses are to observe residents on their shower days to make sure nail care, hair care, shaves and all ADL care is provided and sign off in the electronic record once completed. According to the Electronic Health Record (EHR) R77 was initially admitted into the facility on [DATE] and readmitted [DATE] with diagnoses of moyamoya disease (a rare, chronic, and progressive cerebrovascular disorder that affects the brain's blood vessels), major depressive disorder, diabetes mellitus type two, cerebral infarction (stroke), chronic obstructive pulmonary disease, and quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and torso). R77 was able to communicate consistently during an interview and voice ADL needs. Review of the 7/22/2025 ADL care plan documented, I have an ADL self-care performance deficit related to limited mobility, and moyamoya disease.Interventions as follows:-Dressing: I am totally dependent on staff for dressing.-Person hygiene: I require total assistance with personal hygiene care.-Bathing: I am dependent on the staff to bathe me.There was no documentation for refusal. On 8/25/25 at 1:29 p.m. the Director of Nursing (DON) was asked which staff should provide shaves, nail care and hair grooming to the residents. The DON said the CNAs are to provide nail care i.e., clean, trim, cut and complete shaves and hair grooming on scheduled shower days and as needed. According to the facility's 2/25/2024 Activity Daily Living (ADL) policy: The facility will base the resident's comprehensive assessment consistent with the resident's needs and choices.Policy Explanation and Compliance Guidelines:-3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain .grooming, and personal and oral hygiene.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide vision services in a timely manner for one (R104) of two residents review for vision, hearing, and communication, resulting in the inability to utilize glasses to improve vision and the potential for a decline in vision. Findings include: On 8/19/2025 at 2:02 p.m., R104 was observed in the room sitting at the bedside. R104 presented as alert and oriented to person, place, and situation. R104 was also observed with a wad of white wound care tape on right side of the glasses. R104 said the glasses broke about a year ago and would not be able to get new glasses for another year. R104 said the glasses are not worn often because the white tape gets in the way of seeing at times, I'm supposed to where them every day to see, but I don't. R104 said he was also told there would be a wait to see if they could be repaired. The nurse put tape on the glasses to keep them together and could be worn. R104 said the last vision appointment was about two years ago when the glasses were given. Review of the clinical record documented R104 was admitted into the facility on 2/19/19 with diagnoses that included intraocular lens (an artificial lens implanted in the eye to replace the natural lens, during cataract surgery). According to the annual Minimum Data Set assessment dated [DATE], R104 was cognitively intact (BIMS-15) and required limited one-person assistance with activities of daily living care. The assessment documented R104 had adequate vision and did not have corrective lenses. There was no vision care plan to address vision impairment. There were no nurses or social services progress notes documenting vision impairment or broken glasses. Review of the eye exam consultation dated 6/2/23 eye exam documented the diagnosis of pseudo mania, both eyes and glasses prescription dispensed. Follow-up-prn (as needed). On 8/21/2025 at 2:57 p.m. Social Service Manager (SSM) O was queried about R104's vision needs. SSM O said they were unaware R104's glasses needed repair or replaced. SSM O confirmed R104 was last seen by the doctor 6/2/23 (two years ago), Somehow the resident was not put on the list to be seen. SSM O had no explanation for the absent vision care plan. SSM O said the MDS (Minimum Data Set) assessment was completed by the social service assistant and could not explain the inaccurate information. On 8/21/25 at 3:27 p.m. the Nursing Home Administrator was interviewed and stated, I didn't know (R104) wore glasses, let alone there was a problem with them. On 8/25/25 at 1:56 p.m. the facility was asked to provide a vision or ancillary services policy. The Regional Director of Operations A said the facility did not have the policies.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide adequate pharmacy services when one (R91) of three residents reviewed for medication administration did not have their eye drops available for administration. On 8/20/25 at 9:37 AM during medication administration for R91, Licensed Practical Nurse (LPN) F said the resident's Cyclosporine 0.05% eye drops were not available for administration. An inspection of the medication cart confirmed R91's Cyclosporine 0.05% eye drops were not in the cart. At this time R91 said, I haven't got those eye drops in a while now, maybe 5 - 6 days. They always say they ain't got them. LPN F reviewed R91's Electronic Health Record and said, I requested the pharmacy to refill these eye drops on 8/15/25 and then someone else requested a refill on 8/18/25. I'll call the pharmacy to see where the eye drops are. On 8/21/25 at 10:37 AM R91 reported they did not get all of their eye drops today. Upon further inquiry R91 said, They keep saying they ain't got it. I haven't got those eye drops in the white box (Cyclosporine 0.05%) for a couple days now. I don't know what the problem is. A review of R91's MAR revealed Licensed Practical Nurse (LPN) B had documented R91's eye drops (Cyclosporine 0.05%) were 'administered' for the 8/21/25 10:00 AM dose. On 8/21/25 at 10:40 AM LPN B was interviewed regarding R91's eye drops. LPN B said R91's eye drops (Cyclosporine 0.05%) were not available in the medication cart and therefore not administered. An inspection of the medication cart revealed there were no Cyclosporine 0.05% eye drops for R91. LPN B acknowledged that the Cyclosporine 0.05% eye drops come as individual single-doses in a white box. LPN B confirmed they had documented in the MAR that the eye drops were administered. LPN B then said, Oh, yeah, his (R91's) eye drops are at the bedside. I must have gave them. LPN B went to R91's room and returned to the medication cart with one single-dose eye drop that was unopened and intact. At this time R91 was re-interviewed about the eye drops openly disagreed with LPN Bs recollection of the where the eye drops came from and reported they were not in his room. After consent from R91, the resident's room was inspected. No eye drops or additional medications were observed at the resident's bedside or in their room. On 8/21/25 at 10:49 AM Pharmacist (PH) E was interviewed by phone and reported that on 8/15/25, 30 individual single-dose Cyclosporine 0.05% eye drops were delivered to the facility at 11:15 PM for R91 and signed by LPN D. PH E went on to say that the facility requested another refill on 8/18/25 and was denied because a 15-day supply had just been delivered on 8/15/25. The resident should not need a refill until 8/30/25. PH E could not explain why the eye drops were not available to the administer to the resident. According to R91's Electronic Health Record (EHR) the resident admitted to the facility with multiple diagnoses that include Chronic Obstructive Pulmonary Disease, Diabetes, and history of fractured ribs and sternum. According to the Minimum Data Set, dated [DATE], R91 had no cognition impairment with a brief interview for mental status score of (BIMS) 15/15. A physician's order on 12/12/2024 prescribed the following eye drops: Cyclosporine emulsion 0.05% eye drops, instill 1 drop in both eyes twice a day for dry eyes due to inflammation. A review of the R91's August 2025 MAR indicated that the Cyclosporine 0.05% eye drops were administered everyday as prescribed. A note on 8/15/25 indicated that the pharmacy was requested to refill R91's Cyclosporine 0.05% eye drops. On 8/18/25, a second note indicated that the pharmacy was requested to be refill R91's Cyclosporine 0.05% eye drops. There were no orders are assessments to indicate R91 could self-administer medications or keep them at the bedside. On 8/21/25 at 11:10 AM the Nursing Home Administrator (NHA) was asked about the facility's policy for receiving medications from the pharmacy. Nursing staff should place the resident's medications in the medication cart upon receipt from the pharmacy. The NHA confirmed that LPN D worked the midnight shift on 8/15/25 and that an investigation would be initiated to determine where R91's eye drops were placed after receipt on 8/15/25. A request for the facility's policy/procedure for acquiring medications from the pharmacy was requested. LPN D was unavailable (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for interview during the survey. According to the facility's Medication Administration- General Guidelines (undated); 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. A. Preparation9) If a medication with an active order cannot be located in the medication cart, [OneCare] Pharmacy is contacted.C. Documentation1) 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.

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	08/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review the facility failed to ensure kitchen equipment was maintained in a safe operating condition, resulting in a potential for a delay in food preparation and the safety to staff preparing food. On 8/20/25 at 12:00 P.M., during an observation in the kitchen the South Bend stove was heavily soiled with accumulated baked on food residue and ash. One of the front gas eyes was coated with layers of a (whitish) unknown substance and was covered with soot which impaired the function of the gas eye of the stove. Staff members using the stove were observed constantly readjusting the gas gauges and repositioned cooking equipment because of non-functioning eyes on the stove. The gauges/knobs were present on the stove but were not calibrated adequately causing the bottom of the pans and fryers to be burnt during preparation of the food. Observation of the bottoms of pots and pans stored on racks near the stove were noted to have a coating of burnt on ash and residue from the high temperature. Dietary Manager F acknowledged the facility was discarding skillets because the inner surfaces were damaged. Due to the condition of the stove only one full pan of food could be positioned on the stove for cooking.The South Bend Double Deck Convection oven was soiled with old, accumulated grease and ash. The sides had visible grease residue which could not be easily cleaned due to the position of the adjacent equipment. The racks for both the stove and convection oven appeared to have years of accumulated food residue.Dietary Manager F was interviewed during the observation of the equipment and indicated staff had cleaned and tried to remove the buildup of food residue, but the stoves were old and had years of usage.According to 2013 Food Code section 4-602.13 Nonfood- Contact Surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues