

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Woodward		STREET ADDRESS, CITY, STATE, ZIP CODE 9146 Woodward Ave Detroit, MI 48202	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39958</p> <p>This citation pertains to intake MI00145699.</p> <p>Based on interview and record review the facility failed to ensure adequate assistance during a mechanical lift (Hoyer) transfer for one resident (R601) out of four residents reviewed for falls, resulting in a fracture of the right rib and hospitalization .</p> <p>Findings include:</p> <p>Review of an Admission Record revealed, R601 originally admitted to the facility on [DATE] with pertinent diagnosis which included hemiplegia and hemiparesis following a cerebral infraction. R601 discharged on [DATE] due to a fall and returned to the facility on [DATE] with the diagnosis of Fracture of one rib, right side.</p> <p>Review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R601 had cognitive impairment with a Brief interview for Mental Status (BIMS) score of 8 out of 15 and had impairment on one side of the upper and lower extremities.</p> <p>Review of a nurse's progress note with a date of 7/1/24 at 4:13 p.m. revealed, Event occurred on 07/01/2024 11:30 AM. res was being lifted in hooyer lift and the hooks from the hooyer pad slipped off the hooks of the hooyer lift and res fell to the floor at bedside in his room .(sic)</p> <p>Review of a nurse's progress note with a date of 7/2/24 at 3:10 p.m. revealed, FALL: Writer alert by staff that resident had c/o (complaint) chest pains. Upon immediate assessment resident stated that he had chest pains, and he had a fall. Physical assessment revealed pain 10/10 to right side and chest pains 3/10 . Physician notified and gave order for hospital transfer for post fall evaluation .</p> <p>Review of a care plan revealed R601 had the focus, I have an ADL self-care deficit secondary to history CVA with impaired mobility initiated 7/15/22. Intervention included, I require total assistance with transfers with an initiated date of 7/29/22.</p> <p>Review of a hospital H&amp;P (History &amp; Physical) report dated 7/1/24 revealed, R601 presented to emergency department after a fall from Hoyer lift on the AM of 7/1. A chest x-ray suggested R601 had a fractured right seventh rib.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Woodward		STREET ADDRESS, CITY, STATE, ZIP CODE  9146 Woodward Ave Detroit, MI 48202	
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 8/1/24 at 12:50 p.m., Certified Nursing Assistant (CNA) F reported she transferred R601 with a Hoyer lift without assistance. CNA F reported R601 fall on the bed frame. CNA F reported being aware that mechanical lift transfers required two people and stated, I was irresponsible and got him up by myself, I did not ask for help because there was nobody.</p> <p>In an interview on 8/1/24 at 1:25p.m., the Director of Nursing (DON) reported R601 was sent to the hospital after a Hoyer lift transfer that resulted in fractured right rib. The DON reported CNA F acknowledged that she made a mistake by not waiting for assistance when transferring R601with the Hoyer lift. The DON reported staff are trained upon hire and receive a competency for Hoyer lift use annually. The DON reported the importance of using two people for mechanical lift transfers is to maintain safety.</p> <p>In an interview on 8/1/24 at 2:04 p.m., the NHA (Nursing Home Administrator) reported being made aware that R601 had a fall out of the lift on 7/1/24. The NHA then reported two people are required for mechanical lift transfers.</p> <p>Review of a Mechanical Lift policy revised 12/2018 documented, A mechanical lift will be used to transfer any resident that is totally dependent and immobile . General Guidelines . 2. Do not operate the Hoyer lift alone. Assistance will be needed to guide the resident to another location . 5. The Hoyer lift should always be in good operating condition .</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:</p> <ol style="list-style-type: none"> <li>1. R601 was immediately assessed by the charge nurse and neuro checks, pain assessment and skin assessments completed.</li> <li>2. All mechanical lifts were inspected. The malfunctioning Hoyer lift was removed and stored in a non-accessible area away from staff and new Hoyer lifts were ordered.</li> <li>3. The Administrator and Director of Nursing provided a 1:1 education for the assigned CNA on the Fall Prevention Program, Mechanical Lift, Abuse/Neglect/Exploitation, and Change of Condition polices.</li> <li>4. A facility audit was conducted and like resident care plans were updated.</li> <li>5. The Administrator and DON reviewed the Fall Prevention Program, Mechanical Lift, Abuse/Neglect/Exploitation, and Change of Condition polices and were deemed appropriate.</li> <li>6. All Certified Nurse Aids were educated on Mechanical Lift Transfers with return demonstration to ensure competency with emphasis on needing 2 persons when using a Hoyer lift.</li> <li>7. All staff was educated on the Abuse/Neglect/Exploitation policy.</li> <li>8. The Unit Manager/Designee will conduct audits on observations of mechanical lift transfers on 3 residents M-F weekly for 4 weeks to ensure compliance. Results of these audits will be reported to the QAPI Committee for further review and recommendations</li> </ol> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/01/2024
NAME OF PROVIDER OR SUPPLIER  Mission Point Nsg & Phy Rehab Ctr of Woodward		STREET ADDRESS, CITY, STATE, ZIP CODE  9146 Woodward Ave Detroit, MI 48202	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689  Level of Harm - Actual harm  Residents Affected - Few	9. The Administrator/Designee will audit all Hoyer lifts for functionality M-F for 4 weeks to ensure safety of residents. Results of these audits will be reported to the QAPI Committee for further review and recommendations  The facility was able to demonstrate monitoring of the corrective action and maintained compliance.		