STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235468	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate positioning assistance and safety interventions during incontinence care for one resident (R103) out of three residents reviewed for accidents, resulting in a fall. Findings include: On 3/26/26 at 11:30 AM, R103 was observed awake and lying in a bariatric bed (a specialized, heavy-duty bed designed to safely support plus size or obese people). R103 said they cannot walk or stand but can move about the bed. R103 said they fell out of bed a few days ago during incontinence care. R103 said staff clean them up one side at a time. Staff will have them cross one leg over the other and turn. R103 stated, I didn't know how close I was to the edge of the bed and when I flung my leg over, I slid out of the bed onto the floor. R103 said there was one person changing them at the time. Staff used a mechanical lift plus three people to get them back into bed. A review of the clinical record for R103 documented an initial admission date of 9/14/22 and a readmission date of 2/6/25. R103's diagnoses included acute respiratory failure with hypoxia, morbid obesity, and age-related physical debility. A Minimum Data Set assessment dated [DATE] documented moderate cognitive impairment, no upper or lower extremity impairments, and dependence upon staff for toileting hygiene. Further review of R103's clinical record and post-fall documents revealed in part the following: 1. Nurse progress note date/time of 3/8/26 at 7:05 AM: Writer was alerted to the resident's room at 5:00 AM by CNA (Certified Nurse Aide) who reported that the resident rolled out of bed during care. Upon arrival, resident was observed lying on the floor on (their) left side with the bed noted to be in a low position. Resident was awake and responsive. 2. Fall incident report dated 3/8/25:- Nursing description: Writer was alerted to the resident's room by CNA who reported that the resident rolled out of bed during care. Upon arrival resident was observed lying on the floor on (their) left side with the bed noted to be in a low position.- Resident description: Resident stated (they) rolled out of bed during care.- Staff F statement: CNA reported that during care the resident was asked to turn onto (their) side. While repositioning, the resident continued rolling and inadvertently rolled out of bed onto the floor. (A witness statement from CNA G was not obtained.)- Root cause analysis: Interdisciplinary team met today to investigate, discuss and collaborate on intervention related to fall that occurred on 3/8/26. Investigation found that resident was not positioned in the center of the bed when staff entered to complete resident care rounds. Both CNAs were attempting to position resident in the center of the bed prior to care and resident rolled out of the bed. 3. Nurse practitioner note date/time of 3/11/26 at 3:48 PM: This patient is an [AGE] year-old seen today for evaluation status-post fall. On 3/8/26 nursing staff reported that the patient rolled out of bed during ADL (activities of daily living) care. 4. A review of R103's care plans documented in part the following:Focus: I have an increased risk for alteration in skin integrity secondary to decreased mobility, incontinent of bowel and bladder, extensive assistance with bed mobility and transfers, and bed fast most of the time. I will often refuse to be turned and repositioned and to be changed. Revised 11/9/22. Focus: I have an adl self care performance deficit secondary to history of lymphedema, chronic obstructive pulmonary disease, and obesity. I will often refuse to get out of bed and to be turned and repositioned and to be changed. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident often refuses adl care and brief change.Resident chooses to be bed bound and stay in their room. Revised 2/17/26.Interventions included: Toileting - dependent on staff for toileting. I received care in the bed. Revised 6/9/25. Focus: I have an increased risk for falls and injuries related to falls secondary to cognitive impairment total assistance needed with adl care, incontinent of bowel and bladder, and medication side effects. Revised 12/18/24. During a telephone interview on 3/26/26 at 1:18 PM CNA G said despite R103's size, they are very mobile. CNA G said R103 was not a total assist because they can turn and reposition themselves. CNA G added that R103 was a two-person assist for safety purposes. CNA G said they were in the process of changing R103 when R103 fell from the bed. Regarding the fall of R103, CNA G stated that the two CNAs were positioned on opposite sides of the bed, claiming there was no room for R103 to fall. CNA G reportedly was on the window side of the bed. However, CNA G later said they did not know where CNA F was positioned. When asked directly about their presence during the fall, CNA G asked to end the call and stated, I don't want to answer, subsequently changing their statement to I don't remember. During a telephone interview on 3/26/26 at 1:33 PM, CNA F said R103 was part of their assignment on 3/8/26. CNA F reportedly was positioned on the side of the bed closest to the window when incontinence care was initiated. During the process of turning R103 to provide care, R103 threw their top leg over their other leg and fell out of the bed on the side closest to the door. CNA F said during this time, R103 was not centered in the bed but was somewhat close to the edge. CNA F said CNA G was at the foot of the bed on the side closest to the door when care was initiated. CNA F added that CNA G should have been at the center of the bed on the side closest to the door when care was initiated. On 3/26/26 at 2:00 PM, the Director of Nursing (DON) was interviewed regarding R103's 3/8/26 fall. The DON was unable to provide written statements from CNA F or CNA G regarding R103's fall. The contents of the CNA telephone interviews conducted today were shared with the DON. The DON indicated that if the CNAs were positioned close to the bed on either side, that it would have been reported that R103 bumped into one of them when R103 rolled out of the bed. This was not reported. The DON reported that R103's fall could have been prevented if the CNAs were close to the bed and used a draw sheet to move the resident to the middle of the bed prior to providing care. The DON said it was obvious that education has to be done and follow up provided in this regard. A review of the facility policy titled, Fall Reduction Policy, dated April 2023, documented in part the following:- A fall is an event in which an individual unintentionally comes to res on the ground, floor, or other level, but not as a result of an overwhelming external force (e.g., resident pushes another resident).- A intercepted fall, also considered a fall, is when a resident would have fallen if someone else had not caught the resident from doing so.- When any resident experiences a fall, the facility will: (g.) Obtain witness statements, as applicable. A review of the facility policy titled, Activities of Daily Living (ADLs), dated 2/25/24, documented in part the following:- Care and services will be provided for toileting.- A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. During the exit conference conducted with the DON of 3/27/26 at 11:33 AM, the DON stated that in the future they plan to get handwritten statements from staff regarding investigations.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure resident's medical record accurately documented the administration of prescribed medications (magnesium oxide, metoprolol tartrate, and Seroquel) for one resident (R101). Findings include: A review of the clinical record for R101 documented an admission date of 9/27/25 and discharge date of 3/7/26. R101's diagnoses included acute respiratory failure with hypoxia, hypertension, and bipolar disorder. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. Discharge note of 3/7/26 at 3:33 PM (author Licensed Practical Nurse [LPN] C) documented in part the following: Resident was transferred to local hospital. Reason(s) for Transfer: Behavioral symptoms (e.g. agitation, psychosis). Resident/Responsible party were notified of the reason for transfer. Nursing progress note of 3/7/26 at 3:38 PM (author LPN C) documented in part the following: Writer notified by EMT's (emergency medical technicians) that they were here from a 911 call for resident that stated (R101) was in bed and couldn't get out of the bed. Resident's guardian was notified and gave the okay for EMT's to take resident to hospital for evaluation. Facility physician and DON (Director of Nursing) made aware. Resident transported to local hospital via stretcher. A review of R101's March 2026 Medication Administration Record (MAR) documented that the following medications were administered by LPN H to R101 at bedtime on 3/7/26:1. Magnesium oxide tablet 400 mg. Give 400 mg by mouth two times a day for hypomagnesemia.2. Metoprolol tartrate oral tablet 100 gm. Give 1 tablet by mouth two times a day for tachycardia.3. Seroquel oral tablet 25 mg. Give 1 tablet by mouth two times a day for bipolar On 3/26/26 at 12:54 PM, LPN H was interviewed over the telephone. LPN H said they worked second shift (3:00 PM to 11:00 PM) on 3/7/26. A review of the nursing schedule dated 3/7/26 confirmed that LPN H was assigned to work the second shift on the nursing unit where R101 resided. LPN H indicated that bedtime medications were to be administered at 9 PM, allowing for administration one hour before or after 9 PM. LPN H indicated they could not remember if R101 was in the building around 9 PM on 3/7/26. On 3/26/26 at 1:10 PM, LPN C was interviewed over the telephone. LPN C said R101 was transferred to the hospital on 3/7/26 around 2:55 PM. On 3/26/26 at 2:20 PM, the DON reviewed R101's clinical record and referenced a progress note with a date and time of 3/7/26 at 3:33 PM that indicated R101 was sent to the hospital. The DON indicated the range for bedtime medications to be administered was between 7:00 PM to 10:00 PM. The DON reviewed R101's March 2026 MAR and confirmed the documentation that the bedtime doses of Magnesium Oxide, Metoprolol tartrate, and Seroquel had been administered to R101 on 3/7/26. The DON stated, How can it be administered when the resident was out of the building? The DON added, Someone documented that the medication was administered and the resident had been discharged from the building. On 3/27/26 at 11:33 AM, during the exit conference, the DON indicated education and corrective actions have begun regarding the identified concern.