STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235595	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Physical Rehab Ctr of Detroit	2102 Orleans St Detroit, MI 48207

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 Based on interview and record review the facility failed to ensure an Advance Directive was completed for one resident (R210) of fourteen residents reviewed resulting in the potential for inaccurate life sustaining measures or withholding medical treatment. Findings include: On 12/10/24, at approximately 2:00 PM, record review of the Electronic Medical Record (EMR), revealed R210 was initially admitted into the facility on [DATE] with diagnoses that included Acute Respiratory Failure, and Muscle Weakness. In addition, R210 was being treated for Carbapenem-resistant Enterobacteriaceae, (CRE). CRE is a bacterium which is resistant to certain antibiotics. There was no signed Advance Directive. According to admission Minimum Data Set (MDS) assessment dated [DATE], R210 had moderately impaired cognition. R210 required extensive one-person assistance with activities of daily living (ADLs). On 12/12/24 at 9:10 AM, Social Worker G was interviewed regarding R210's Advance Directive and said while looking and calling other parties the signed hard copy of R210 Advance Directive could not be located. SW G said they know the importance of having an Advance Directive is to honor patient's wishes. On 12/12/24 at 2:50 PM, the Director of Nursing was interviewed, and confirmed there was no Advance Directive for R210. The DON said the importance of having an Advance Directive for residents is to abide by the resident's wishes.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview, and record review the facility failed to revise care plans in a timely manner for three residents (R10, R260, and R7) out of 14 residents reviewed for care planning. Findings include: R10 On 12/10/24 at 9:59 AM R10's guardian was interviewed and stated that R10 has had recent falls and was concerned. Record review of R10's electronic health records (EHR) revealed admission into the facility on [DATE] with pertinent diagnoses of epilepsy, and traumatic brain injury. According to the Minimum Data Set, dated dated dated [DATE], R18 had severely impaired cognition and was dependent for Activities of Daily Living (ADLS). Record review of R10's fall report dated 10/6/24 revealed that Resident observed on floor next to bed laying on his back no c/o (complaints) pain nor distress noted, resident verbally responsive. Record review of R10's active care plans revealed the following: Focus: I had an actual fall on 10/6/24 revision on 12/11/24. Goal I will exhibit less behaviors resulting in me placing myself on the floor. Date initiated 10/6/24 created on 12/11/24. Interventions: keep resident occupied with activities while awake. Date initiated 10/6/24 created on 12/11/24. On 12/11/24 at 11:44 AM the Director of Nursing (DON) was interviewed and said R10's fall care plan was updated on 12/11/24 after the 10/6/24 fall was identified during the survey. The DON agreed the 10/6/24 care plan update was not timely and ideally should be updated within 24 hours of the fall. R260 Record review of R260's electronic health records (EHR) revealed admission into the facility on [DATE] with pertinent diagnoses of cellulitis of right orbit and other psychoactive substance abuse. According to the Minimum Data Set, dated dated dated [DATE] R260 had intact cognition. Record review of the physician's orders revealed hydroxyzine HCL oral tablet 50 mg give 1 tablet by mouth every 4 hours as needed for anxiety start date 11/19/2024. Review of the December 2024 Medication Administration Record (MAR) revealed R260 received hydroxyzine on 12/3/24, 12/8/24, 12/9/24, and 12/10/24. Review of R260's care plan did not reveal an anxiety diagnosis and/or anxiety medication care plan. On 12/11/24 at 4:06 the Director of Nursing (DON) was interviewed and said R260 received an anti-anxiety medication and agreed there should be a care plan for anxiety and hydroxyzine. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15194 R7 On 12/12/24 at 8:30 A.M. review of the admission record for R7 documented the resident was admitted to the facility on [DATE] with pertinent diagnoses which included: history of falls, chronic obstructive pulmonary disease, chronic kidney disease stg 3, schizophrenia, morbid obesity and pulmonary embolism. According to the minimum data set (MDS) dated [DATE], R7 was cognitively intact with periods of confusion, had long and short-term memory deficits and required 2 person assist for transfer. Record review of R7 Electronic Health Record and Falls care plan documented on 10/29/24, revealed R7 had a witnessed fall. According to the report a Nursing Student reported R7 fell on the floor attempting to transfer to bed and hit his head on the floor R7 stated he was trying to get into bed and lost his balance. On 10/29/24 R7 was transferred out of the facility for further evaluation to rule out head trauma secondary to anti-coagulant therapy. Record review of R7 Care Plan revealed the following Focus: I am at increased risks for falls r/t BLE weakness initiated, created and revised 8/15/24. Goal My risk for falls Will be reduced through the next review date initiated 12/1/24, created 8/15/24, revised 12/9/24. Further review of the falls care plan revealed no evidence the facility revised or reviewed the original Fall care plan dated 8/15/24. Per the facility's interventions revisions of care plan will occur quarterly and after each fall.

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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 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** 15194 Based on observation, interview and record review the facility failed to provide hair care for one resident (R1) of 14 sampled residents reviewed for activities of daily living (ADL), resulting in poor grooming. Findings include: On 12/10/24 at 1:25 P.M. R1 was observed sitting in the hallway outside of her room. R1's hair was observed loose around the front portion of the resident's face and the back braids had scattered patches of unbraided rows. The resident's scalp was dry in appearance and unkempt. R1 was observed on 12/11/24 at 12:00 P. M during lunch in the main dining room and on 12/12/24 at 8:14 A. M. exiting the elevator going to activities. R1's hair was not groomed, and the resident's hair remained in the same condition as it was observed on 12/10/24. Review of the Admission Record for R1 indicated the resident was admitted to the facility on [DATE], with diagnoses that included: Down Syndrome, Diabetes Mellitus, dry eye syndrome, seizure disorder and other symptoms and signs involving cognitive function. According to the Minimum Data Set (MDS) dated [DATE], R1 was severely impaired in cognitive skills for thinking, was rarely or never understood and was incontinent of bowel and bladder. On 12/12/24 at 9:10 A.M., review of the Care Plan titled: Activities of Daily Living (ADL) self-care performance deficit related to Down Syndrome, initiated 9/20/22, indicated R1 was dependent on staff for personal hygiene (meaning the resident does none of the effort to complete the activity which) included combing hair, shaving and applying make-up. On 12/12/24 at11:10 A.M. License Practical Nurse (LPN) B was interviewed concerning the appearance of R1's hair. LPN B indicated the Nurse Aides were responsible for combing resident's hair every day and R1's hair was usually braided and oiled on her shower days. LPN B indicated R1 shower days were Mondays and Thursdays. LPN B was queried if R1 hair was groomed on Monday, 12/9/24. The nurse indicated she was not sure because the one nurse aide who normally combed R1's hair had not been scheduled on the unit that week. LPN B was asked to observe the resident's hair. During the observation the nurse's stated Not all the nurse aides on the unit, know how to braid hair and when the one aide that could braid hair was off or on vacation, there was no one else except maybe a nurse to braid the resident's hair. Review of the Task assignment for R1 revealed no documented evidence R1 received hair care on Monday or any day for the month of November and/or December. On 12/12/24 at 11:30 A.M. the Director of Nursing (DON) was interviewed concerning R1's hair. The DON indicated the nurse Aides were responsible for ensuring resident's hair was washed and groomed on shower days. The DON was not able to provide a reason why R1's hair wasn't combed or brushed the days of observation. The facility's policy was requested related to Activities of Daily Living but was not provided upon exiting the facility at 4:30 P.M.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47964 Based on interview, and record review the facility failed to consistently provide one resident (R5) out of three residents reviewed for limited range of motion (ROM) a restorative therapy. Findings include: On 12/10/24 at 11:44 AM, R5 was interviewed and stated, I'm not getting any rehab or exercises. I'd like to because my shoulder is starting to hurt more. Record review of Electronic Health Record (EHR) revealed R5 admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke) and paraplegia (paralysis that affects the lower half of the body). Review of the Minimum Data Set (MDS) dated [DATE] for R93 revealed a Brief interview for Mental Status (BIMS) 15/15 intact cognition and functional limitation in range of motion impairment to both upper extremities. Record review of the physical therapy discharge summary note dated 10/14/24 with Physical Therapist (PT) A revealed discharge recommendations: patient referred to FMP (functional maintenance program). Functional maintenance program established/trained = range of motion program. Range of motion program established/trained: 15 rept x 2 sets (15 repetitions for 2 sets). Prognosis to maintain CLOF (currently level of function) = good with consistent staff follow-through. PT A said he did not complete a therapy to restorative form on 10/14/24 but should have and agreed R5 should be having a ROM program. Record review of the EHR did not reveal a therapy to restorative form completed for the physical therapy discharge on 10/14/24. Further review of the EHR for R5 revealed no orders, care plan and/or Kardex for a restorative ROM program. On 12/11/24 at 1:20 PM R5's restorative log was requested for October 2024 but was not provided. Review of R5's November restorative log revealed 15 minutes of ROM was provided on 11/13/24. Dates 11/15/24 through 12/11/24 revealed not applicable. There were no refusals of a ROM program noted in the EHR. On 12/11/24 at 4:06 the Director of Nursing (DON) was interviewed and said R5 was not receiving restorative services and should have been and that the restorative log should not have been marked not applicable. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Restorative Nursing Programs revised 6/23/24 revealed in part . It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. The discharging therapist, restorative coordinator, or designated licensed nurse will communicate to the appropriate restorative aide, the provisions of the resident's restorative nursing plan, providing any necessary training to carry out the plan. Restorative aides will implement the plan for a designated period, performing the activities and documenting in the clinical record.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 15194 Based on observation, interview, and record review the facility failed to ensure a sanitary physical environment in the Dietary Department, resulting in a potential for contamination of food from soiled ceiling tiles and corroded, rusted vents. This deficient practice had the potential to affect 50 residents that received meals and/or food from the kitchen. Findings include: On 12/11/2024 at 12:00 P.M. during a follow up observation in the kitchen four of five ceiling vents were observed soiled with grease, rust and corroded discolored areas. The tiles around the perimeter of the vent exiting the doorway to the tray line had visible black, greasy, lint spots. During the observation Dietary Manager C was queried concerning who was responsible for cleaning of the vents in the kitchen. The manager indicated the department had a porter who had recently cleaned the vents, but the areas observed on the vents were rust and the vents needed to be replaced. The manager indicated the outer portions of the vents had been recently cleaned but the inner lining and adjacent ceiling tiles required deep cleaning or replacement by the Maintenance Department. On 12/11/24 at 1:40 P.M. Maintenance Director D was interviewed concerning the cleaning of the vents and ceiling tiles in the kitchen. Maintenance Director D reported the maintenance department was only responsible for cleaning the facility's vent throughout the building, but that cleaning did not include cleaning the vents in the Dietary Department. On 12/12/24 at approximately 1:00 P.M. the Director of Nursing (DON), in the absence of the Dietitian & Administrator, was made aware of the conditions of the vents and ceiling tiles in the kitchen. The DON was asked to observe the vents and ceiling tiles around the vents in the kitchen. On 12/12/24 at 2:00 P.M. during the Quality Assurance Interview the DON indicated observation of the ceiling vents and tiles were noted and stated the soiled tiles and rusted vents needed to be replaced Review of the facility's policy titled, Cleaning Interior vents, dated 1/11/2021, stated in part The Plant/OPS Maintenance Department vent cleaning should be performed throughout the entire facility quarterly to ensure compliance. Avoid servicing the Dining room or kitchen vents during mealtimes or when food is exposed. The policy did not identify who was responsible for cleaning of the vents in the kitchen area. On 12/12/24 at 4:00 P.M., according to the 2019 Food Code under 6-501.12 and 6-501.14 stated(A) Physical facilities shall be cleaned as often as necessary to keep them clean, (B) Except for cleaning that is necessary due to spill or other accident, cleaning shall be done during periods when the least amount of food is exposed such as after closing. 6-501.14(A). Cleaning ventilation systems, Nuisance and Discharge Prohibition. (A). Intake and exhaust air ducts shall be cleaned, and filters changed so they are not a source of contamination by dust, dirt, and other materials.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50634 Based on observation, interview, and record review the facility failed to implement preventative measures for one resident (R210) of one resident reviewed for transmission-based precautions. was free from the potential spread of infectious pathogens. Findings include: Record review of the Electronic Medical Record, (EMR) clinical record documented R210 was initially admitted into the facility on [DATE] with diagnoses that included Acute Respiratory Failure, and Muscle Weakness. In addition, R210 was being treated for Carbapenem-resistant Enterobacteriaceae, (CRE). CRE is a bacterium which is resistant to certain antibiotics. According to the admission Minimum Data Set (MDS) assessment dated [DATE], R210 had moderately impaired cognition 11/15 (BIMS), Brief Interview for Mental Status. R210 required extensive one-person assistance with activities of daily living (ADLs). On 12/11/24 at 12:50 PM, Certified Nursing Assistant, (CNA) H was observed to take R210's lunch tray into the room. CNA H did not use any personal protection equipment, (PPE). There was PPE located outside of the room. The door was marked for Transmission based precautions. The room door was left open and it was observed that R210 did not receive an isolation tray. On 12/11/24 at 2:40 PM, CNA H was queried about R210 and said R210 gets a regular tray it comes on regular dishes. CNA H was asked if there were any special precautions for R210. CNA H said only when providing patient care. On 12/11/24 at 2:45 PM, CNA I was queried and indicated that a regular tray (a tray with regular dishes) was given to R210 and was returned to the kitchen. On 12/11/24 at 3:00 PM, Licensed Practical Nurse, (LPN) F was interviewed and she said R210 was on precautions for a respiratory infection. LPN F added they wear PPE when they provide personal care for R210. LPN F was queried if there was a difference in the meal tray for residents on transmission-based precautions, LPN F explained on day shift R210 received a regular tray and on night shift R210 receives Styrofoam trays. LPN F said she is not sure why R210 receives the Styrofoam at night. On 12/12/24 at 2:50 PM, the Director of Nursing, (DON) was interviewed and said R210 even though they had completed antibiotics they would remain on transmission-based precautions until test results came back clearing them. The DON said R210 would be receiving all their meals on Styrofoam Record review of the facilities infection prevention and control program dated 4/17. The program is designed to provide a safe sanitary and comfortable environment. This program is to help prevent the development of communicable diseases and infections. When a resident has an identified they shall be placed on transmission-based precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy also stated, All staff will receive training relevant to their role and responsibility regarding the infection prevention and control program. Staff will also demonstrate competence related to infection control practices. Furthermore, there will be an annual review of the policy and based on that review any needed updates will occur.