Printed: 11/20/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235619	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church of Christ Care Center	23575 15 Mile Rd Clinton Township, MI 48035

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 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** This citation pertains to intake 1238202.Based on observation, interview, and record review, the facility failed to provide 1:1 feeding assistance for one resident (R16) and grooming assistance for one resident (R20) out of three reviewed for Activities of Daily Living (ADL). Findings include:R16 On 8/18/2025 at 10:44 AM, R16 was observed in bed. R16 was noted to be sitting with the head of bed (HOB) elevated and a clothing protector on. The bedside table was pulled over them and their breakfast tray was sitting in front of them. R16 was noted to have a hash brown and eggs on their clothing protector and eggs on their face. R16 was observed attempting to pick up their eggs with their fingers. The meal ticket was noted to have 1:1 assistance and highlighted in yellow. A review of the medical record revealed that R16 was admitted into the facility on 1/6/2022 with the following diagnoses, Cerebrovascular Disease and Alzheimer's Disease. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 0/15 indicating an impaired cognition. R16 also required assistance with bed mobility and transfers. Further review of the physician’s orders revealed an active order dated 5/15/2025 for 1:1 assistance with feeding. On 8/18/2025 at 1:17 PM and 1:30 PM, R16 was observed in their room with their lunch tray in front of them. No one was observed in the room assisting R16 with eating. R16 was observed with chicken and green beans on their clothing protector and chin. On 8/20/2025 at 9:19 AM, Certified Nursing Assistant (CNA) “A” was asked if R16 requires assistance with feeding. CNA “A” reported R16 does better in the dining room, but if they are in the room then they need assistance and encouragement to eat. On 8/20/2025 at 9:35 AM, an interview was conducted with Registered Dietitian (RD) “B”. RD “B” reported R16 needs more assistance with their meals, and it can sometimes take them a while to get warmed up. On 8/20/2025 at 12:16 PM, an interview was conducted with the Director of Nursing (DON). The DON reported that if a resident requires feeding assistance, then they should be fed and get the help that they need. R20 (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/18/2025 at 9:41 AM, R20 was observed sitting in their wheelchair in the hallway. They were observed to have facial stubble that appeared to be unshaven for approximately three to four days. Review of the facility record for R20 revealed they were admitted into the facility on [DATE] with diagnoses including Hypertensive Heart Disease with Heart Failure and Mood Disorder with Depressive Features. Due to the limited time since admission, R20's Minimum Data Set (MDS) information was not available however the resident's baseline care plan indicated they required one-person assistance for self-care tasks. On 08/20/2025 at 1:09 PM, R20 was observed during an interview to continue to have longer facial stubble unshaven since the 08/18/2025 observation. They were asked if they preferred to have their facial hair growing out or to be cleanly shaven and they reported they preferred to stay clean shaven but they have trouble doing it themselves. They were asked if the staff assist them to shave and they stated They have but not very often. On 08/20/2025 at 1:23 PM, Certified Nursing Assistant (CNA) K reported they had provided care for R20 on a regular basis. CNA K was asked if they assist R20 to shave and they reported A male aide shaves [R20] on their shower days twice a week. On 08/20/2025 at 1:31 PM, the facility Director of Nursing (DON) reported that being shaved on shower days is the current facility protocol unless requested otherwise by the resident. The DON was asked if resident's preference for frequency of shaving is assessed upon admission and they reported the preference for frequency of shaving is not specifically addressed during establishment of the care plan. Review of the facility policy titled Activities of Daily Living dated 08/03/20 revealed the policy statements 3. 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 .4. The resident's needs and care approaches will be updated in the care plan and reviewed on an as needed basis.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1238200.Based on interview and record review the facility failed to utilize the required two staff to complete incontinence care for one sampled resident (R4) of four residents reviewed for accidents, resulting in a fall from the bed and a fracture of the right arm. Findings include:During a closed record review of R4's medical record it was noted that R4 was transferred to the hospital after a fall during care. A review of R4's medical record progress notes revealed, 8/17/25 -Writer called to room by nurse assistance. Res (resident) observed on floor, lying on right side. Lying next to bed closest to the window. Nightstand and bed side table next to [R4], close to [R4's] head. Res is alert and verbal. Verbal complaints of pain to right side. Physician in house. Assessed at bedside while on floor. Order received to send to ER (Emergency Room) via 911. Res kept in same position. No active bleeding noted at this time. Awaiting EMT's (Emergency Medical Technicians).Further review revealed, 8/17/25 -Physician Progress Note: Patient was seen today per nursing request due to the above-mentioned concern. No fever or chills no chest pain or SOB (Shortness of Breath) no abdominal pain no headache. Patient fell out of bed during care, [R4] landed on [R4's] right side, [R4] reported that [R4] struck [their] head against on the floor. [R4] is on Eliquis (blood thinner) due to a history of A-Fib. [R4] complains of pain over right arm and wrist. No LOC (Loss of Consciousness). [R4] complains of pain over right arm and wrist. Assessment and plan; 1. S/P (status post) fall on Eliquis 2. Closed head injury, no LOC 3. Paroxysmal atrial fibrillation; on Eliquis 4. Morbid obesity 5. Old CVA (cerebrovascular accident) with right hemiparesis 6. Debility; continue supportive care 7. Plan of care was discussed with nursing Call 911 and transfer patient. to ER for further evaluation and treatment. A continued review of R4's medical record revealed that R4 was admitted to the facility on [DATE], readmitted on [DATE], and discharged [DATE]. A review of R6's Minimum Data Set quarterly assessment dated , 7/3/25 noted R4 with an intact cognition.A review of R4's care plan revealed, . Focus: Self Care Deficit r/t (related to) Physical Weakness, poor endurance, bilateral cataracts, right hemiparesis, and impaired mobility. Goal: Resident Care needs will be met daily. Interventions: Bathing: I am dependent on 2 staff members to provide for my bathing needs. Dressing: I require extensive assistance of 2 staff to assist me with dressing. I am incontinent of bowel and bladder and require total assistance of 2 staff to provide incontinence care. Bed Mobility: I require extensive assistance of 2 staff member and my right-side enabler bar for bed mobility.Toileting Provide extensive assistance with personal hygiene care: nails, hair, oral care, bathing. PHO Care: I am incontinent of bowel and bladder and require total assistance of 2 staff to provide incontinence care. BED MOBILITY: I require extensive assistance of 2 staff member and my right side enabler bar for bed mobility. On 8/20/2025 at 1:18 PM, the Director of Nursing (DON), called R4 at the hospital for an interview regarding the fall. R4 explained they were being assisted by Certified Nursing Assistant (CNA) N to get ready for the day. R4 explained CNA N was the only CNA in the room. R4 continued and explained, they were rolled on to their side and CNA N turned to get the cream for their bottom and that is when they rolled out of bed. R4 stated they hit their head, and their arm was in pain after the fall and was transferred to the hospital.The DON was asked their expectations for following the care plan. The DON explained, staff is to follow the minimum number for staff assistance and to follow the Kardex (CNA care guide). The DON confirmed R4 stated they had an Acute proximal humerus fracture of the right arm. On 8/20/2025 at 3:56 PM, CNA N was asked via phone about the fall with R4. CNA N explained it was during care they asked R4 to grab the bar to turn to the side, because they had a small bowel movement. CNA N explained they had turned their back to get the cream and that is when R4 fell out the bed. CNA N was asked if they knew R4 was a two person assist for ADLs. CNA N confirmed they did know but was unable to locate another staff person to help at that time. A review of the facility's policy titled, Fall prevention Program dated, 2/5/22, noted Policy: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. Policy Explanation and Compliance Guidelines .3. Interventions will be implemented by the care team.