STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 22960 Based on observation and interview, the facility failed to maintain resident overbed tray tables in resident rooms (rm) C137, D144, D148, D150, D151 and D156, failed to maintain the sink vanity in rooms C138, C142, and C143, failed to maintain the privacy curtain in room D151, and failed to maintain the ceiling ventilation covers in the main dining room and the fishbowl lounge. Findings include: On 2/4/25 at 9:30 AM, there were 3 ceiling vent covers located in the main dining room that were coated with dust. In addition, there were black mold-like stains on the ceiling surrounding one of the ceiling vents. When queried at that time, Maintenance Manager I provided no explanation. On 2/4/25 between 9:35 AM-9:45 AM, there were overbed tray tables observed with missing plastic edging and exposed rough particle board in Rms D150, D151, D156, in the hallway being utilized for a breakfast tray for the resident in Rm D148-2, in the hallway being utilized for paperwork for the resident in Rm 144-1, and a tray table in the hall by the nurse's station, with the top surface covered in contact paper that was peeling off in large sections. On 2/4/25 between 9:45 AM-9:50 AM, rooms C138, C142, C143 were observed with sharp edges on the sink vanity corners, with missing laminate and rough, exposed particle board. On 2/4/25 at 2:45 PM, Maintenance Manager I was queried about the overbed tray tables, and stated that he was aware of the problem, but that the facility was only able to replace 2 tables per month. When queried about the sharp edges on the sink counters, Maintenance Manager I stated they would be fixed. 30675 On 2/4/25 at 9:32 AM, Room D151-1 was observed to have privacy curtains soiled with dark brown debris. On 2/4/25 at 10:00 AM, Room D148-1 was observed to have an overbed tray table that had peeled away edges which exposed the particle board (porous material) underneath. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations from 2/4/25 - 2/5/25 also identified concerns in the fishbowl lounge which had a large ceiling vent (approximately 3 feet x 3 feet) which had a thick layer of dusty build-up on the outside grid covering. The bathroom in the hallway just outside of the fishbowl lounge was observed to have a ceiling fan that was covered in thick, stringy, heavy dust build-up on the outside of the vent grid. On 2/5/25 at 1:30 PM, an interview was conducted with the Maintenance & Housekeeping Manager (Staff 'I'). When asked about their staffing for both housekeeping and maintenance staff, Staff 'I' reported they were fully staffed and had staff at the facility seven days a week and typically staggered the schedule either 7:00 AM to 3:00 PM or 8:00 AM to 4:00 PM. When asked if housekeeping would be responsible for maintenance/cleaning of the vents such as in the bathrooms and lounges, Staff 'I' did not give a clear response but reported the facility had contracted with a new company that would take care of the vents three times a year. When asked about routine cleaning/maintenance more frequently, Staff 'I' did not offer any further response. When asked about the soiled privacy curtains and what the process would be if they were identified by staff they were soiled, Staff 'I' reported they used an electronic reporting system called Maintenance Care that anyone can go in and put in but denied any concerns with privacy curtains. When asked about the overbed tray tables, Staff 'I' reported they had previously identified the need to replace those items, but currently they were only able to replace two tables a month. When asked about the concerns with residents eating on these tables and inability to properly sanitize due to porous surfaces exposed, Staff 'I' acknowledged the concern but reported currently they were only able to replace two a month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure accurate assessments were completed for two (R26 and R58) of 17 residents reviewed for Minimum Data Set (MDS) assessments. Findings include: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual. Link to the LTCF RAI User's Manual: https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf: .an accurate assessment requires collecting information from multiple sources .Those sources must include the resident and direct care staff on all shifts, and should also include the resident's medical record, physician . R26 Review of the clinical record revealed R26 was admitted into the facility on [DATE] with diagnoses that included: acute kidney failure, end stage kidney disease (ESRD), and dependence on renal dialysis. According to the Minimum Data Set (MDS) assessment dated [DATE], section O0110J1 which prompted the staff completing the assessment to answer yes or no if the resident received dialysis was incorrectly marked as No. Review of R26's physician's orders identified the resident had been scheduled for dialysis every Tuesday and Saturday since their admission into the facility. On 2/4/25 at 3:50 PM, an interview was conducted with the MDS Coordinator (Nurse 'E'). When asked about why they documented R26 as No for dialysis, when they had been on dialysis prior to and since admission into the facility, Nurse 'E' reported they didn't think she was on dialysis. When asked how that was not identified if during their assessment of reviewing orders, assessments, and progress notes, those documents all indicated R26 was on dialysis, Nurse 'E' reported that was missed and would have to complete a MDS correction. 39592 R58 Review of the closed record revealed R58 was admitted into the facility on [DATE] with diagnoses that included: dementia, atrial fibrillation and hypertension. According to the MDS assessment dated [DATE], section A2105 which prompted the staff completing the assessment to pick where the resident was discharged to, the choice of Short-Term General Hospital (acute hospital, IPPS {Acute Inpatient Prospective Payment System Hospital}) was incorrectly marked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/25 at 3:51 PM, Nurse 'E' was interviewed and asked why it was documented R58 went to a hospital when it was documented R58 went to an assisted living facility. Nurse 'E' explained she knew R58 went to assisted living and must have hit the wrong button.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure assessments, monitoring and treatments were provided for one (R27) of two residents reviewed for non-pressure wound care. Findings include: On 2/4/25 at 9:59 AM, R27 was observed lying in their bed. A bordered gauze dressing was observed on R27's left forearm. The dressing was undated and had serosanguineous (fluids containing blood and the liquid part of blood) drainage visible approximately 1-1.5 centimeters (cm) in diameter. Another gauze dressing was observed taped to R27's left upper arm, directly above the elbow and was dated 2/2/25. R27 was asked about the bandages on their left arm. R27 explained they were not sure why the bandages were there, but had been there a while. Review of the clinical record revealed R27 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: metabolic encephalopathy, heart failure and diabetes. According to the Minimum Data Set (MDS) assessment dated [DATE], R27 had moderately impaired cognition and required the assistance of staff for all activities of daily living (ADL's). Review of R27's February 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no orders for wound care/dressing changes. Review of R27's progress notes revealed a Nursing Note dated 2/1/25 at 4:21 AM by Licensed Practical Nurse (LPN) D that read in part, resident rolled at [sic] of bed at 3am . assess for injuries. skin [sic] tear on left forearm noted. Review of a facility provided INTERDISCIPLINARY POST FALL REVIEW dated 2/1/25 read in part, .Injury: No Injury .If injury occurred specify: skin tear left forearm . Injury Type: Unable to determine .Injury Location: Left antecubital (inner elbow) . Review of a Weekly Skin Sweep dated 2/1/25 at 11:42 AM read in part, .Please choose the skin condition that was observed: Rash/excoriation .Site: left blank .Description: left blank . No further skin conditions were documented. Review of R27's assessments revealed no additional Weekly Skin Sweeps or wound assessments. On 2/5/25 at approximately 9:15 AM, LPN A, who served as the Wound Care Nurse, and Dr. B, a Consultant Wound Provider, were observed preparing to enter a resident room near R27's room. LPN A explained they had just finished with R27's wounds. LPN A and Dr. B were asked about the dressings on R27's wounds. LPN A explained they did not know anything about R27's left arm dressings. It was explained there was an undated dressing with visible drainage on R27's left forearm and gauze taped to R27's left upper arm dated 2/2/25. Dr. B explained they would go back to R27's room after finishing up the room they were about to enter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/5/25 at 9:27 AM, Dr. B was observed removing R27's left forearm dressing, measured the wound as 1 cm x 0.6 cm x 0.2 cm, and explained it was a skin tear. Dr. B then removed the gauze from R27's left upper arm, measured the wound as 1.6 cm x 1 cm and 100% covered by slough (non-viable tissue), and could not explained the etiology (cause) of the wound but suspected it was from a trauma. R27 was asked how long the dressings had been on their left arm. R27 explained the dressing were put on when they got to the facility, and had been there ever since. On 2/5/25 at 10:25 AM, LPN D was interviewed by phone and asked if he had put a dressing on R27's left arm after their fall on 2/1/25. LPN D explained he had put a dressing on a skin tear on R27's forearm, but did not know about a dressing on R27's left upper arm. LPN D was asked if he had called the doctor and put an order in for dressing changes. LPN D explained he remembered calling the doctor, but could not remember if he had put an order in for dressing changes or not. On 2/5/25 at 1:11 PM, the Director of Nursing (DON) was interviewed and asked about R27 having one undated dressing and one dated 2/2/25 with no physician orders. The DON explained if a nurse is putting a dressing on a resident, they should ensure they are calling the physician to get a correct treatment and put an order in for dressing changes. The DON was asked what should happen if a nurse notices a dressing on a resident. The DON explained if a nurse sees a dressing, they should ensure an order is in place and if not, what is under the dressing. Review of a facility policy titled, Wound Treatment Management and Documentation revised 2/2024 read in part, .Wound treatments will be provided in accordance with physician orders .In the absence of treatment orders, the licensed nurse will notify the physician to obtain treatment orders . Treatments will be documented on the Treatment Administration Record .Wound assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. Wound treatments are documented at the time of each treatment .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on interview and record review, the facility failed to ensure consistent dialysis communication documentation and assessments were completed for one (R26) of one resident reviewed for dialysis. Findings include: Review of the clinical record revealed R26 was admitted into the facility on [DATE] with diagnoses that included: acute kidney failure, end stage kidney disease (ESRD), and dependence on renal dialysis. According to the Minimum Data Set (MDS) assessment dated [DATE], this assessment failed to identify the resident was currently receiving dialysis services. Review of R26's physician's orders identified the resident had been scheduled for dialysis every Tuesday and Saturday since their admission into the facility. A physician order started on 12/10/24 documented the nursing staff were to .in the morning every Tue, Sat for ESRD please send dialysis communication sheet. Review of the resident's dialysis communication documentation which included both the electronic medical record (EMR) assessments, progress notes, and the hard copy/handwritten documentation scanned into the EMR revealed concerns with the lack of documentation of the facility's communication and/or assessment of R26 pre and post dialysis for six dialysis treatments on 12/14/24, 12/21/24, 12/28/24, 1/4/25, 1/11/25, and 1/18/25. There was a progress note on 1/18/25 at 6:45 PM which read, Paperwork sent with resident to dialysis was not returned with resident after dialysis. However, there was no documentation that the facility had attempted to follow-up (communicate) with the dialysis center for further details. On 2/4/25 at 4:00 PM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for dialysis communication and assessment, the DON reported there were assessments in the EMR as well as communication sheets that were sent with the resident. The DON was informed there were only three dialysis communication forms scanned into the EMR for review and was requested to provide any additional documentation. On 2/5/25 at 8:30 AM, the DON was asked about any additional dialysis documentation for R26 and they reported that was a concern and confirmed assessments and documentation were missing and would be working on revamping the process and educating staff. According to the facility's policy titled, Dialysis Special Needs Care Plan dated 6/2023: .Nursing staff will provide a report to the dialysis provider regarding the resident's condition and treatment provisions each dialysis treatment day, and as needed .If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49083 Based on observation, interview and record review, the facility failed to ensure appropriate storage of medications and treatments/biologicals in two of three medication rooms, one of one treatment cart, and one of four medication carts, resulting in potential for unauthorized entry, misuse, and contamination. This deficient practice has the potential to affect all residents. Findings include: On 2/5/25 at 8:37 AM, during a medication administration observation with Licensed Practical Nurse (LPN) H retrieval of medication was required from the medication room on the A/B Hallway. The medication storage room door was opened by LPN H and they proceeded to prop the door open with a red emergency (crash) cart. After retrieving medication from the A/B medication storage room, LPN H exited the medication room leaving the door propped open. On 2/5/25 at 9:07 AM, an observation of the A/B medication room remained unlocked and propped open by the emergency (crash) cart. No nursing staff was observed present in the area. On 2/5/25 at 9:24 AM, an observation of medication cart on A hall was conducted with LPN D. The following medications were observed in drawer: there were two loose pills that were not in a package and had no patient identifiers. Additionally, there was one yellow round tablet, one yellow capsule, one blue/white capsule, and one oblong pink pill. LPN D acknowledged the medications were not stored properly and was observed disposing them into the sharps container on the cart. On 2/5/25 at 11:42 AM, the medication storage room on D hall was observed with LPN H. Upon opening the refrigerator, there were numerous bags of unopened insulin pens for multiple residents stored inside. Many insulin pens were observed stored in a purple plastic bowl, next to a large opened container of applesauce. There was a half-opened container of orange juice stored on the door, and the covered door shelf was opened and revealed four individually wrapped packages of red grapes that were covered in a white mold-like substance. On 2/5/25 at 1:11 PM, an interview with the Director of Nursing (DON). When informed of the concerns regarding the observations of the medication storage, the DON acknowledged staff had brought the findings to their attention. The DON confirmed the medication rooms were not to be propped open or left opened. The DON further reported that the condition of the refrigerator on D hall was unacceptable and medications and food were to be stored separately. 30675 On 2/5/25 at 9:52 AM, observation of the D hall revealed the treatment cart was unlocked and unsupervised (there was no Nurse or staff in the hallway and/or view of the cart). There were three residents seated in the hallway near the cart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/25 at 9:56 AM, Nurse 'H' returned to the medication cart which was stored right next to the treatment cart. When asked about whether they were aware the treatment cart was unlocked, Nurse 'H' reported they didn't notice that. When asked if they had used the treatment cart today, Nurse 'H' reported they did not use it at all today and proceeded to access the laptop on the medication cart without securing the treatment cart. The Nurse did not secure the treatment cart until prompted by this surveyor. According to the facility's policy titled, Medication Storage in the Facility dated June 2019: .Only nurses, pharmacists, and pharmacy technicians are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access . Refrigerated medications are kept in closed and labeled containers and separate from fruit juices, applesauce, and other foods used in administering medications .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 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. 22960 Based on observation, interview, and record review, the facility failed to maintain the kitchen in a sanitary manner. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 2/4/25 between 9:00 AM-9:30 AM, during an initial observation of the kitchen with Dietary Manager (DM) J, the following items were observed: In the Traulsen reach-in cooler, there was a pan of raw chicken stored directly on top of a box of cooked diced chicken, and raw pork stored on top of a box of corn chowder soup. DM J confirmed the food items were not stored properly. According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation, (A) Food shall be protected from cross contamination by: .(2) Except when combined as ingredients, separating types of raw animal foods from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display by: .(b) Arranging each type of food in equipment so that cross contamination of one type with another is prevented,. The ice scoop holder was observed with black debris on the inside bottom surface. DM J stated it would be run through the dish machine. According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: .(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food) . The hose sprayer at the soiled side of the dish machine was observed hanging down and touching the soiled drain board. DM J stated he would have Maintenance turn the spring around. According to the 2017 FDA Food Code section 5-202.13 Backflow Prevention, Air Gap. An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonFOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Holly	313 Sherwood St Holly, MI 48442

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49083 Based on observation and interview, the facility failed ensure appropriate infection control practices (handwashing and/or use of hand sanitizer) for two residents (R48, R9) out of four observed for medication administration. This deficient practice has the potential for spread of infection that could potentially affect all residents residing in the D Hall. Findings include: On 2/5/25 at 8:37 AM, a medication administration was conducted with Licensed Practical Nurse (LPN) H for R48. Hand hygiene was not observed prior to preparation, administration, and after administration of four ordered oral medications. LPN H was observed returning to the medication cart and retrieved an unopened box of ordered Artificial Tears (lubricating eye drops). The unopened box of medication was taken back to R48, hand hygiene was not observed, LPN H donned a pair of clear disposable gloves, proceeded to open the box of medication and remove the safety seal on the bottle gloved, then administered one drop into each eye of R48. After administration, LPN H voluntarily admitted that they realized they had not performed hand hygiene. On 2/5/25 at 9:02 AM, LPN H was observed for medication administration to R9. The ordered Gabapentin (an anticonvulsant medication) was not available in the medication cart and required LPN H to retrieve from a medication room off the unit. After retrieval of the medication, the medication was observed being administered without hand hygiene. On 2/5/25 at 1:11 PM, an interview was conducted with the Director of Nursing (DON). When the DON was informed of the concerns with lack of proper hand hygiene during medication administration, the DON acknowledged the concerns and reported hand hygiene should be performed prior and post medication administration. Review of the facility's policy titled; Hand Hygiene dated 1/2024 documented: .Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice .