

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 5/6/2025
NAME OF PROVIDER OR SUPPLIER MISSION POINT NSG & PHY REHAB CTR OF WARREN			STREET ADDRESS, CITY, STATE, ZIP CODE 11525 E TEN MILE RD WARREN, MI 48089	
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E0000 SS=	Initial Comments On May 6, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey Mission Point of Warren was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
K0000 SS=	INITIAL COMMENTS On May 6, 2025 a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Mission Point Nursing & Physical Rehab Center of Warren was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a 1 - story building of Type II (222) construction with a partial basement, built in 1966. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 167 certified beds. At the time of the survey the census was 122. The requirement at 42 CFR, subpart 483.90(a) is NOT MET as evidenced by:	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

05/21/2025

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.

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K0211 SS= E	<p>Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview the facility failed to ensure aisles, passageways, corridors, exit discharges, exit locations and accesses are in accordance with Chapter 7. This deficient practice could affect 50 occupants in the event of a emergency evacuation through the staff entrance.</p> <p>Findings Include:</p> <p>On May 6, 2025, at approximately 11:00 AM observation revealed the emergency egress path outside the staff entrance doors is under construction due to underground pipe replacement. The ground is broken and filled with gravel and the area is barricaded off to prevent foot traffic. This may delay or prohibit evacuation through the doors during an emergency evacuation.</p> <p>These findings were confirmed thorough interview with the maintenance director at the time of observation.</p>	K0211	<p>Element 1 On April 11, 2025, maintenance staff immediately cleared items and made a pathway for all cited exit areas, including the northwest exit and exit near Room 411. Signs were temporarily posted indicating caution until the area was verified safe and useable again.</p> <p>Element 2 All residents in units adjacent to and reliant upon the affected exits (northwest hallway and near Room 411) were assessed for potential risk. No residents experienced adverse effects as a result of the obstruction.</p> <p>Element 3 All maintenance and housekeeping staff were in-serviced on May 6, 2025, regarding the revised policy and procedures.</p> <p>Element 4 The Director of Maintenance or designee will audit all exits daily during week x5 days a week for a month, then once weekly for 2 months. Findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee monthly for review and further recommendations. The administrator is responsible for the sustained compliance.</p>	6/5/2025
K0222 SS= E	<p>Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR</p>	K0222	<p>Element 1 On May16, 2025, maintenance staff installed highly visible signage ("Push to Exit" and "Emergency Exit Release") above and beside all magnetically locked egress doors. A staff member was assigned to test each door's</p>	6/5/2025

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	<p>SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</p>		<p>emergency function to verify operability.</p> <p>Element 2 All residents were evaluated for reliance on egress doors for safe evacuation. No residents were affected by the magnetic locking system during the time of inspection.</p> <p>Element 3 All emergency exit devices were tested facility-wide for compliance. Staff training was conducted on May16, 2025, to review emergency door operation, including the use of magnetic locks and identifying signage. Monthly egress drills will now include checks of all egress door systems, including magnetic locks.</p> <p>Element 4 The Maintenance Supervisor will conduct monthly tests of each egress door's emergency release function and verify signage placement and visibility. Audit results will be documented and reviewed in monthly Safety Committee meetings. Trends or failures will be escalated to QAPI for corrective planning. The administrator is responsible for the sustained compliance.</p>		

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K0363 SS= E	<p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure doors in a required means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side unless meeting the special locking arrangements for delayed egress in accordance with 19.2.2.2.5.1 and 19.2.2.2.6. This deficient practice could affect 30 occupants in the event of an emergency evacuation.</p> <p>Findings Include:</p> <p>On May 6, 2025, at approximately 11:30 AM observation revealed the 300 unit delayed egress emergency exit door does not activate the delayed egress release process when pressure is applied to the door. This may prohibit or delay emergency evacuation during an emergency.</p> <p>These findings were confirmed through interview with the maintenance director at the time of observation.</p> <p>Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors</p>	K0363	<p>Element 1 On May 14, 2025, maintenance personnel adjusted and repaired the door to Room 302 to ensure full closure and smoke resistance. A door sweep was installed on the door near Room 410 to eliminate the excessive gap. Element 2</p>	6/5/2025

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	<p>in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure doors protecting corridor openings are capable of resisting the passage of smoke as required by NFPA 19.3.6.3. This deficient practice could affect 50 occupants in the event of a smoke or fire event.</p>		<p>A facility-wide audit of all corridor doors was completed on May14, 2025. No other deficiencies in corridor door function were identified. All residents in proximity to the affected rooms were found safe and unaffected. Element 3 All facility doors were checked for compliance with smoke resistance standards on May 14, 2025. Staff were educated on May16, 2025, on reporting improperly closing doors to the maintenance department immediately. Element 4 The Director of Maintenance or designee will complete monthly corridor door inspections to ensure doors close and latch properly and resist the passage of smoke. Results will be recorded and reviewed during QAPI meetings. Any failure will prompt immediate repair and re-education. The administrator is responsible for the sustained compliance.</p>	

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K0781 SS= E	<p>Findings Include:</p> <p>On May 6, 2025, at approximately 10:30 AM observation revealed the fire rated cross corridor doors between the main lobby to the main corridor hallway do not fully close to resist the passage of smoke and fire. This will allow heat, smoke and fire to pass through the corridor doors into the adjacent compartments.</p> <p>These findings were confirmed through interview with the maintenance director at the time of observation.</p> <p>Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure portable space heating devices shall be prohibited in all health care occupancies. This deficient practice could affect 15 occupants in the event of space heater related fire.</p> <p>Findings Include:</p> <p>On May 6, 2025, at approximately 10:15 AM observation revealed a portable space heater running in the Human Resources Office. The space heater could not be verified to not exceed 212 degrees Fahrenheit. This may lead to a space heater related fire.</p> <p>These findings were confirmed by the</p>	K0781	<p>Element 1 On May 6, 2025, the portable space heater identified in the Human Resources Office was immediately removed from the facility and placed in secure storage pending disposal. A sweep of all administrative, clinical, and non-clinical areas was conducted the same day to identify and remove any other unauthorized space heaters. None were found. The Maintenance Director confirmed removal and documented the action.</p> <p>Element 2 A full facility audit of all office, administrative, breakroom, and storage areas was completed to ensure no other prohibited portable heating devices were present. All residents were evaluated for potential risk exposure. No resident rooms or care areas contained space heaters, and no resident was adversely affected.</p> <p>Element 3 On May 8, 2025, the facility reviewed its Electrical Equipment and Fire Safety Policy. Education was provided to clearly state that all portable space heaters are prohibited, unless explicitly approved in writing by the Administrator and Maintenance Director and</p>	6/5/2025	

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	maintenance director through interview at the time of observation.		confirmed to not exceed 212°F and only used in nonsleeping staff areas. A mandatory in-service training was conducted on May 16, 2025, for all department heads, including Human Resources, Administration, Maintenance, and Nursing, regarding fire safety compliance and the prohibition of portable space heaters under NFPA 101. Element 4 Beginning May 16, 2025, the Director of Maintenance or designee will perform monthly environmental safety rounds, with documentation confirming no prohibited space heaters are in use. Any unauthorized heating devices found will be immediately removed and reported to the Administrator and Safety Committee. Compliance findings will be reviewed monthly during the facility's QAPI meetings for 6 months and quarterly thereafter. The administrator is responsible for the sustained compliance.		