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	834980	A. BUILDING _____ B. WING _____	**4/2/2025**

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MISSION POINT NSG & PHY REHAB CTR OF ELMWOOD	**1881 E GRAND BLVD DETROIT, MI 48211**

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F0000 SS=	INITIAL COMMENTS Mission Point Nursing and Physical Rehabilitation Center of Elmwood was surveyed for an Abbreviated survey on 4/2/25. Intakes: MI00150446, MI00150510, MI00151417, and MI00151479 Census= 103	F0000		
F0684 SS= G	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00150510. Based on observation, interview, and record review the facility failed to assess and monitor one resident (R602) from four residents reviewed for change in condition resulting in lack of monitoring, assessment, and the failure to administer emergency medical care/treatment in a timely manner. The resident subsequently died while in the facility. Findings include: Review of a Facility reported incident revealed the following:	F0684	Element 1 Resident 602 no longer resides at the facility. Element 2 Current residents are at risk for requiring emergency care or experiencing adverse events if Change of Condition is not recognized and assessed in a timely manner. Education was completed prior to survey including review for other residents to determine any ongoing needs secondary to Change in Condition. A follow up 1x audit was completed for past 3 days to determine any residents experiencing a Change of Condition that required further assessment or monitoring. Concerns were addressed as needed. Element 3 Current staff were re-educated on Recognizing Change of Condition and steps to take regarding needed assessments and monitoring. Licensed nurses were re-educated on needed assessments, documentation and notification when a Change of Condition is recognized. Staff who do not receive the education by the date of compliance will receive education on the day of work. Non-compliance with the education on the day of work. Non-compliance with the	4/22/2025

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

Electronically Signed | 04/17/2025

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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	Incident Summary: It was reported by Midnight staff cena's (Certified Nurse Assistant/CNA) and resident (R605) who was (Resident 602's) roommate that at approximately 5 am (R605) went to (Registered Nurse "A") who was on duty Midnight nurse scheduled 7 pm-7:30 am that patient (R602) was in distress and required assistance. When (Registered Nurse "A") didn't come to check (R602), (R605) again went and told (Registered Nurse "A") that (R602) still requires assistance. (CNA "D" and CNA "B") who were assigned to 4th floor both notified (Registered Nurse "A") that (R602) didn't look good, (Registered Nurse "A") observed (R602) and stated (R602) was snoring. Dayshift nurse (Nurse "E") came on duty at 7 am and observed (R602) in wheelchair slumped back, (Nurse "E") immediately assessed patient who had a faint pulse who was unarousable (Nurse "E") began emergency measures." A review of R602's electronic medical record revealed an admission to the facility on 1/17/2024 with the diagnoses of Syncope, Osteoarthritis, Myocardial Infarction (Heart Attack) Hypertension, Chest Pain, Leg Pain, Leg Swelling, Shortness of Breath, and Diabetes Mellitus. A review of R602's Brief Interview for Mental Status (BIMS) dated 1/23/2025 revealed a score of 15/15 (cognitively intact). A review of R602's care plan revealed the following: "Focus-I have potential for altered cardiovascular status r/t (related to): Hypertension, dated 1/17/2024 ... Intervention-Assess for chest pain ...Assess for shortness of breath ...Monitor/document/report to MD changes in lung sounds ... Monitor/document/report to MD (Medical		education will result in 1:1 education or written discipline per policy. System Change: Increase Monitoring Element 4 DON/designee will complete audits of 24 hour report for Change of Condition including any needed Assessment and Documentation daily M-F x 4 weeks then weekly x 4 weeks and ongoing per QA committee recommendations. Results of audits will be reported to QAPI monthly x3 months and PRN. DON is responsible for ongoing compliance.	

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	Doctor) Chest pain or pressure especially with activity, shortness of breath, excessive sweating, dependent edema, Vital Signs ...Intervention-I have altered respiratory status ...Intervention-Administer medication ...Monitor for effectiveness and side effects Monitor/document/report to MD dated 12/27/2024 ...monitor for decreased pulse oximetry, increase heart rate, restlessness, diaphoresis, headaches, lethargy, confusion dated 12/27/2024 ..." Review of R602's progress notes revealed a history of R602 experiencing episodes requiring acute care as follows: 1.) A review of R602's progress note dated 11/23/2024 at 07:36 am revealed the following: "Resident slid from w/c (wheelchair) onto the floor observed per writer. Resident is nonresponsive to verbal stimuli able to move all limbs free of pain..." A review of the electronic medical record revealed that R602 was transferred to the hospital on 11/23/2025. R602 returned to the facility on 11/25/2025 with the diagnosis of heart attack. 2.) A record review of R602's progress note dated 12/24/2024 revealed the following: "12/24/2024 18:22 (6:22pm) Nursing Progress Note Approx. (approximately)4:45pm Writer was doing rounds. Writer observed (R602) sitting in (their) wheelchair with (R602) head tilted back unresponsive. Writer performed a sternum rub. (R602) was not able to respond to verbal stimuli, but able to respond to tactile stimuli. (R602) was able to come to conscious. (R602) was not able to			

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	tell me (their) name, date, or reason for (their) stay. (R602) became very lethargic, diaphoretic, and drowsy. Writer phoned on call (physician) New orders put in place to send (R602) to (hospital). Approx.5 pm 6 person (Emergency Medical Technician/EMT) arrived to transport resident to (hospital). (R602) refused any further treatment from EMT. (R602) refused EMT to get any vitals or EKG (electrocardiogram a noninvasive test that records the heart's electrical activity). Writer informed (R602) of the dangers of (their) health if (they) refused to get further treatment. EMT did not take (R602). Approx. 5:26pm writer observed (R602) unresponsive again sitting up in (their) wheelchair with (their) head tilted back. Writer performed sternum rub, this time (R602) did not come to conscious. Writer applied rebreather mask @8L of oxygen. VSS (vital signs)BP 116/58, P(Pulse) -115, R (Respiration)-24, SPO2(oxygen saturation)-94% on 8L (Liters), B/S(Blood Sugar)-178. Writer phoned 911. Approx. 5:30pm 6 person EMT arrived again to transport (R602) to (the hospital) ..." A record review of R602's progress note dated 1/23/2025 revealed the following: "1/23/2025 15:59 Nursing Progress Note Note Text: Resident went LOA (leave of absence) for cardiac referral. Diagnosis/reason was that resident had 2 episodes of chest pain in nursing home ...Resident returned with recommendations for multiple cardiac referrals. Follow up appt/ (follow up appointment) referral is Thursday February 20th @ 11:30AM for all testing. Continue with POC (plan of care)." Record review of the facility's "Statement of Staff member" dated 2/10/2025 revealed the following:			

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	"CNA "B": I was doing my work and around 5am (R605) (R602's roommate) came to me and (CNA "D") and said (their) roommate (R602) was having a seizure ...(CNA D) ran to room 408 right away and I went to tell the nurse (Registered Nurse "A"). (Registered Nurse "A") said that (R602) is just sleeping and (R602) always snores. I (CNA "B") left the nursing desk and went checked myself, the resident did not look good. (R602) was in the wheelchair with (their) head tilted back, mouth wide open and white foam coming out of (R602's) mouth. I (CNA "B") went back to nurse (Registered Nurse "A") telling (the nurse) (R602) does not look right and please come and see (R602). (Registered Nurse A) stated again (R602) was asleep ...I (CNA "B") went back finishing up my work. I asked nurse (Registered Nurse "A") to come and check on (R602), (Registered Nurse "A") is the nurse I cannot make (them). A record review of staff witness CNA "D" interview dated 2/9/2025 revealed the following: "Starting to do my last changes, (R605) came and stated (R602) was having a seizure. Me and the nurse (Registered Nurse A) went to the room trying to get in the room around 5oclock am, (R602) had the door jam shut ...(R605) came back and told me (R605) got into the room I (CNA "D") went around there and saw(R602) getting no response I (CNA "D") went to (Registered Nurse A) to come check on (R602). I did more changes (and) went back to (R602 and asked (Registered Nurse "A") to come check (R602) again. (Registered Nurse "A") said (R602) was sleep ... (CNA "D") and CNA "B" waited on dayshift and notified them what was going on ..." On 2/10/25, a record review of (R605) (R602's roommate) was interviewed by the Director of Nursing (DON):			

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	"(R605) said around 5 in the morning, (R605) heard some noise, got out of bed and saw (R602) having a seizure with white stuff coming from (R602's) mouth. I (R605) then went to the nursing station to tell the nurse (Registered Nurse "A"). The nurse said okay, but didn't move so I said it again. The nurse went down there but couldn't get in the room so (Registered Nurse "A") walked away. I (R605) pushed on the door moving stuff around and was able to open the door. I (R605) went back to tell the nurse (Registered Nurse "A") the door was opened, (Registered Nurse "A") went to the room and said (R602) was just sleeping." (R605) said I am so sad, I should have call 911 myself." A record review of staff witness Nurse "F" interview dated 2/9/2025 revealed the following: "Arrived this morning in (sic) clocked in at approximately 6:53 am. Next I went up to the floor that I was assigned to which was the 3rd floor. After doing my rounds and receiving report from the night nurse. That's when a CNA from midnights came to where I was and asked if me and the night nurse could come help with a situation happening on the fourth floor. Upon arriving on the 4th floor, I could visibly see (R602) in room (redacted) unresponsive in (their) wheelchair ...did not respond. Then that's when I began doing CPR and about 6-7 minutes later that's when EMS arrived and took over from there." Review of the facility's "Statement of Staff member" Registered Nurse "A" dated 2/10/2025, interviewed by the DON, revealed the following: "The roommate (R605) approached (Registered Nurse "A") at the nursing desk informing me (Registered Nurse "A") that (R602) was having a seizure and had foam coming from his mouth			

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	around 5a.m. (Registered Nurse "A") went to the room and the door was blocked, the door would not open. I (Registered Nurse "A") was thinking how did (R605) get out of the room and what was blocking the room?...I (Registered Nurse "A") was in the middle of doing something so I (Registered Nurse "A") went back to the nursing desk to complete what I was doing and several minutes later some (sic) told me they was able to get the door opened ...I don't remember who told me. Then, I went back to the room and (R602) was snoring and what was not unusual for him. I did not see any clonic or tonic activity, no seizure activity at all. No acute distress noted, (R602) was sleeping and I did not see any foam coming from (R602's) mouth ..." Registered Nurse "A" was asked by the DON: "How did you ascertain no acute distress was noted, did you perform an assessment, obtain vital signs or attempt to arouse (R602)?" Registered Nurse "A" said: "No, as I said it was not unusual to see him snoring in the same position and there was no foam around (R602) mouth." A review of the electronic medical record progress note written by Nurse "E" revealed the following: "Upon entering shift @0700, writer was making rounds and found resident (R602) unresponsive and when writer was calling resident's name, resident was unarousable. Writer was doing sternal rubs and checking for pulse. Resident (R602) had a faint pulse. Residents skin was warm and dry to touch. During transfer for CPR, residents (R602) extremities were easy to extends and flex. VS (vital signs) were taken BP (blood pressure)154/124, Resp (Respiration)14. 911 was immediately called and arrived within minutes.			

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	Nursing staff began CPR immediately and CPR assistance from EMS and firefighters took over at 0714. CPR and defibrillator use continued. By 0741 EMS staff called the hospital in order for the physician to pronounce resident deceased. Resident (R602) was pronounced deceased @ 0741." A record review of the electric medical record progress note written by Registered Nurse "A" revealed the following: "2/9/2025 08:07 Nursing Progress Note: Note Text: (R602) was snoring in (their) wheelchair in front of the TV in (R602) room when Day Shift staff came in and could not arouse him from his sleep. EMS was called and 2 EMS crews arrived within minutes. EMS staff lowered him from his wheelchair to the floor to work on him. At 7:14 AM CPR with a defibrillator was still underway. By 7:41 AM the EMS staff called the hospital to let a physician pronounce (R602) as deceased ...(R602) was last seen awake and watching TV in (their) room by Midnight CNA at 2:30 AM. At close to 6:00AM (R602) roommate (R605) said thinks (R602) may have had a seizure though none was witnessed by staff ..." On 4/1/2025 at 1:01 pm, CNA "B" was interviewed via phone and queried about the incident that occurred with R602. CNA "B" said (R605) (R602's roommate) came to them (CNA "B" and CNA "D") and said something was wrong with R602. CNA "B" said that they went to R602's room at about 5 am and R602 did not look right. CNA "B" went to Registered Nurse "A" and said something was wrong with R602. Registered Nurse "A" said the resident (R602) was sleeping. CNA "B" said that they (CNA "B") went back to R602's room and R602's head was			

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	tilted back and R602's mouth was opened with foam coming out of their mouth. CNA "B" went back to Registered Nurse "A" and said, "Please look at (R602) because (R602) wasn't looking right." CNA "B" said that Registered Nurse "A" kept saying that R602 was sleep. CNA "B" denied observing Registered Nurse "A" return to the room to check on R602. On 4/1/2025 at 1:17 pm, CNA "D" was interviewed via phone and queried about the incident that occurred with R602. CNA "D" said that (R605) (R602's roommate) approached them at a different time other than when reported to CNA "B" said something was going on with the R602 and someone needed to look at R602 ...CNA "D" said that R602's wheelchair was blocking the door (from the inside) and they had trouble getting into the room. CNA "D" said that Registered Nurse "A" said that he saw R602 and R602 was sleeping. CNA "D" went back to R602's room and R602 "did not look good." CNA "D" said that they went back to Registered Nurse "A" and said that R602 was not looking good but Registered Nurse "A" said they was not going back in there (the room) because R602's was sleep. CNA "D" reported not observing Registered Nurse "A" return to the room to check on R602. On 4/1/2025 at 2:56 pm, an attempt was made to interview Registered Nurse "A." A male voice answered the phone. After this writer made a self-introduction, the phone connection was loss. At 2:58 pm, another attempt was made to contact Registered Nurse "A," a voice message was left with contact information. On 4/1/2025 at 3:42pm, Nurse "F" was interviewed via phone and queried about the incident that occurred with R602. Nurse "F" said they came to work a little before 7 am on			

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	2/9/2025. Nurse "F" said that a CNA from the midnight shift asked them to come to the fourth floor because something had been going on with R602 for "a while." I went to the fourth floor and R602 was unresponsive, that's when I started CPR. Nurse "F" said that Registered Nurse "A" was not in the room. On 4/2/2025 at 11:34 am, an interview was conducted with the NHA and DON related to the care R602 received on 2/9/2025. The DON stated, "When I think about this, it was horrific." The DON explained that both CNA "B" and CNA "D" tried telling Registered Nurse "A" that something was going on but Registered Nurse "A" said that the resident (R602) was sleep. The DON added that R605 went to Registered Nurse "A" and said that the resident (R602) wasn't "okay" and had "froth" coming out of (R602) mouth. The DON said that they asked Registered Nurse "A" if the two CNAs told him that something was wrong and Registered Nurse "A" said "Yes" but had other things "to do." The DON said Registered Nurse "A" was terminated because they failed to recognize a change in condition. The NHA said that if a resident was not safe or well, any staff could call 911. R605 was unavailabe for interview as they had been discharged from the facility. Day Shift Nurse "E" was unable to be contacted by phone. A review of the facility policy "Change in Condition" revised on 7/2024 revealed the following: "The organization utilizes an interactive platform in the electronic health record to recognize and manage a potential change in condition."			

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	The facility submitted the "Resident Assessment Critical Element Pathway." However, the provided document did not provide guidance for how staff react or respond to resident change in conditon.			