| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235214 | A. Building<br>B. Wing | 07/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mission Point Nursing & Physical Rehabilitation Ce | 535 N Main<br>Clawson, MI 48017 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): 1278772. Based on observation, interview and record review, the facility failed to protect the resident's right to be free from physical abuse by a resident for two (R203 and R204) of four residents reviewed for abuse, resulting in R204 physically assaulting R203 (witnessed by R205 and R207) causing a scalp laceration that required three staples, a hematoma and swelling of the left eye, and expressions of fear of returning back to the facility from the hospital and R204 sustaining scratches to his nose, under right eye, and neck. Findings include:A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) revealed an allegation that (R203) was arguing with his roommate (R204) and hit him. No injuries noted. It was documented the incident occurred on 6/20/25 at 6:00 PM. On 7/8/25 and 7/9/25, an unannounced onsite investigation was conducted.A review of a Case Report completed by the local police department revealed they were called to the facility for aggravated/felonious assault. The following was documented in the Narrative section of the report: On the listed date and time (6/20/25 at 7:47 PM), (Officers' names) were dispatched to (facility address) (room number) for an assault and battery .the assault occurred at 5:50 PM .the patients were separated but one needed to be transported to the hospital for the injuries The nurses stated that two patients, lodged in the same room, got into a physical altercation. The nurses stated that they did not witness the assault .and advised officers that both suffer from dementia I met with the victim, later identified as (R203). (R203's) left side of his face was swollen and bloody. (R203's left eye was black, bruised, and swollen. (R203) had a fresh cut above his left eyebrow that was bleeding. There was a laceration on the top of (R203's) hairline. (R203's) left ear was bruised and the back of (R203's) neck was red. I took pictures of (R203's) injuries (R203) stated that him and the suspect, later identified as (R204), are not friends, but they share the same room together. (R203) advised me that he was laying down in his bed and (R204) jumped on him and started to hit him in the face. (R203) was unable to give me specific details about the assault due to his mental state (Officer name) met with (R204). (R204) stated that he was okay but was unable to give officers specific details about the assault due to mental state (Ambulance company) arrived on scene and transported (R203) to (hospital name) for his injuries .A review of R203's hospital records revealed the following:An ED (Emergency Department) Provider Note documented, .(R203) . presents to the emergency department due to assault .Physical exam shows scalp laceration, left periorbital edema (swelling around the eye) .Patient knew his name, location, however would intermittently answer questions inappropriately .Laceration was cleansed with sterile water and was repaired with staples .Patient states he does not feel safe going back to this facility, as he was assaulted by his roommate .Results from a CT (computed tomography) revealed, Preseptal hematoma (collection of blood that pools on the septum of the nose after trauma) of L (left) orbit (eye socket) without acute orbital fracture.On 7/9/25 at approximately 11:55 AM, R203 was observed in bed, in the dark, with the privacy curtain pulled around the bed. R203 was queried about any altercations with his previous roommate and R203 stated, My ear hurt worse than being here. I want to leave. R203 said he lived in Japan and did not speak English, despite speaking English at that time. R203 was not able to clearly answer questions about the alleged event. On 7/9/25 at 9:00 AM and 11:53 AM, R204 was observed sleeping. R204 did not respond when addressed.A review of R203's clinical record revealed R203 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Multiple Sclerosis (MS). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R203 had severely impaired cognition and no behaviors. A review of R203's progress notes revealed the following documentation:On 6/9/25, a Nursing Progress Note documented, approximately 10:30pm (R203) and roommate (R204) began arguing. Resident (R203) stated that roommate was sitting on his bed and that he wanted his sheets changed. CNA (Certified Nursing Assistant) reported that (R203) was agitated because (R204) is always walking around the room and going through his belongings. Words were exchanged and roommate was redirected back to his bed. Roommate (R204) was placed on a 1:1 (supervision), NP (Nurse Practitioner) on call notified, DON (Director of Nursing) notified, Administration notified.On 6/14/25, the following was documented in a Behavior Note, .Upon approaching the dining room. Resident observed throwing a cup towards another resident and yelling using profanity. A CNA was trying to intervene, and resident kicked the CNA in the stomach .What additional interventions were put in place to keep others safe? Residents should be monitored in the dining area at all times .On 6/20/25, the following was documented in a Nursing Progress Note written by Licensed Practical Nurse (LPN) 'C'. Around (5:50 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake(s): MI00153082, MI00154080 & MI00154105.Based on observation, interview and record reviews the facility failed to conduct a thorough investigation into an injury of unknown origin for one (R202) of four residents reviewed for Abuse. Findings include:On 7/8/25 at 1:24 PM, R202 was observed sleeping in their bed. Three attempts were made to wake the resident with verbal stimuli, however all attempts were unsuccessful. A review of the medical record revealed R202 was initially admitted to the facility on [DATE] with diagnoses that included: dementia, history of unspecified adult abuse, and the need for assistance with personal care. R202 was noted to be under hospice services. Review of a progress note dated 4/30/25 at 12:36 PM, documented in part . Writer observed swelling to resident's right hand. NP (nurse practitioner) made aware and new orders were given.Review of a complaint submitted by the local Police Department documented the following in part . She (R202) had a large bruise on her hand and told staff that someone on staff had beat her up. (R202) will not reveal who this is. (R202 name) has dementia. Officers attempted to get (R202) to tell who had assaulted her and she said that she did not want to tell us who did it .Review of a 5 Day Investigation Summary submitted by the facility's Administrator documented in part . (R202) had a bruise on her right hand stating . that someone beat her up . (R202) is combative with care. According to staff reports she will grab things like curtains, bed frames, people etc. when she doesn't want to be changed . (R202) does have documented behaviors including combativeness with care and her care plan has been updated to include two-person assistance due to her combative behavior .Review of the progress note revealed the following:A Nursing: Incident Note dated 6/25/25 at 8:45 AM, documented . Nurse aide reported that resident had new skin concern, writer assessed resident and noted bruising swelling and pain to right back and front of hand at second third and fourth knuckle. Resident stating someone did it to her .A Nursing note dated 6/25/25 at 8:50 AM, documented in part . Nurse aide . notified writer that resident had a new injury to right hand, writer assessed resident and noted red and light purple discoloration and increased swelling to right hand at second third and fourth knuckle accompanied by increased pain set at 8. Resident stated someone grabbed her hand hard because they didn't like me. Resident stated her pain is at an 8 and was unable to make a fist .A Nurse Practitioner (NP) note dated 6/26/25 at 10:16 AM, documented in part . Because x-ray was unable to come to patient, facility transferred patient to hospital via EMS (emergency medical services) for hand x-ray .Review of a hospital After Visit Summary dated 6/26/25, documented in part . x-ray showed a displaced fracture in your right hand . Diagnosis Closed displaced fracture of distal phalanx of ring finger, unspecified laterality .A review of the facility's investigation file included the following:A statement by CNA A that documented the following I was (R202) Cena last night. The nurse went into the room with me to give her care. She wasn't combative, she let me change her. I just talked to her and was rubbing her arm so she would stay calm. I didn't see anything on her hand. She has <sic> no signs of Pain or discomfort .Review of a 5 Day Investigation Summary submitted by the Administrator documented in part . On Wednesday, June 25, 2025 . a bruise on resident's right hand and was informed by (R202 name) that someone bent her finger. (local police department name) were notified . It remains inconclusive how the injury specifically occurred .Review of a complaint submitted by the local police department documented in part . It was first reported on 6/25/2025. (Facility Administrator) reported that they had suspended (Certified Nursing Assistant - CNA A) after it was determined that she did not follow protocol by not being alone in the patient's (R202) room. It was reported that (R202) had a habit of grabbing things. She (Administrator) stated that staff are not supposed to pry patient's hands, due to the risk of injury. (Administrator) reported that (CNA A) pried (R202's) hand off . Officers were dispatched back to the facility where (R202) was transported for a fractured hand .CNA A is a night shift aide that was identified to be assigned to R202 for the night of 6/24/25 into the morning of 6/25/25. The injury to R202's right hand was identified by the morning aide on 6/25/25. A review of a care plan titled I have potential to demonstrate behaviors . I am combative with care, hitting staff, grabbing my bed frame so staff are unable to complete care with right hand . an intervention documented . Two staff to be present during care at all times . Initiated 5/7/25. On 7/8/25 at 12:29 PM, an attempt to conduct a telephone interview with CNA A was unsuccessful. CNA A's voicemail box was full, so a text message was sent regarding the investigation and a request was made for them to return the surveyor's call. A review of CNA A time card revealed no documentation of a suspension noted. On 7/8/25 at 3:50 PM, Licensed Practical Nurse (LPN) G (the midnight nurse assigned to R202 on 6/24/25 into the morning of |

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| F 0839<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Employ staff that are licensed, certified, or registered in accordance with state laws.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews the facility failed to ensure a Certified Nursing Assistant (CNA) maintained an active CNA certification while working at the facility, for one (CNA A) of three CNA certifications reviewed. Findings include: A review of CNA A's personnel file revealed a LAPSED status of their nursing assistant certification (nurse aide certification). The document revealed the certification expired on [DATE]. A review of CNA A timecard revealed the aide worked in the facility as a CNA with a lapsed certification on the following dates:[DATE]/[DATE]/[DATE]On [DATE] at 2:02 PM, an interview was attempted with CNA A but was unsuccessful.On [DATE] at 2:40 PM, the Administrator was interviewed and asked about CNA A's nursing aide certification to have been lapsed since [DATE], while still working in the facility as a CNA. The Administrator replied the facility did not have a Human Resource (HR) personnel in house but comes to the facility throughout the week. The Administrator stated the HR Personnel was in the building and they would follow up with the concern. On [DATE] at 3:00 PM, the Human Resource personnel (HR) B was interviewed and stated they are in the facility once a week. HR B stated they realized yesterday ([DATE]) when (CNA A personnel file was requested by the survey team) that CNA A nursing aide certification had lapsed and informed the Administrator. HR B stated the facility staff got in contact with CNA A and the CNA was able to get their certification fixed. At that time HR B was asked to finish the interview in the office of the Administrator. The Administrator was again asked about CNA A nursing aide certification to have lapsed while still working in the facility as an aide. The Administrator acknowledged the concern.No further explanation or documentation was provided by the end of the survey. |