STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235290	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	828 East Washington Street Greenville, MI 48838

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit 1 resident (R102) of 3 residents reviewed to return to the facility following hospitalization. Findings include: Review of an admission Record revealed R102 admitted to the facility on [DATE] with pertinent diagnoses which included pneumothorax (a condition when air enters the chest and the lung collapses) and mild intellectual disabilities. Review of R102's Nursing Progress Note dated 3/28/2025 at 4:48 AM revealed R102 was sent to a local hospital complaining of difficulty breathing and was intentionally hitting himself. Review of R102's Transfer Notice dated 3/28/2025 revealed R102's reason for transfer was pneumothorax. Review of R102's Nursing Progress Note dated 3/28/2025 at 12:52 PM revealed R102 was admitted to the local hospital for spontaneous pneumothorax. Review of R102's Social Service Progress Note dated 3/28/2025 at 10:18 AM revealed Social Services Manager (SSM) G suspected undiagnosed mental health issues and requested the local hospital psychiatric department to evaluate R102 before his return to the facility. Review of the Electronic Medical Record (EMR) revealed R102 did not return to the facility and no further documentation was found to explain why he did not return after his hospitalization. In an interview on 5/6/2025 at 9:45 AM, SSM G reported she reached out to the company's admissions staff and requested R102 have a mental health workup while he was at the local hospital prior to his return. SSM G reported she did not know why R102 did not return to the facility following his hospitalization. In a telephone interview on 5/6/2025 at 10:58 AM, local hospital social worker A reported R102 was ready to discharge back to the facility after his 3/28/2025 hospitalization and the hospital therapy department was still recommending sub acute rehab. Local hospital social worker A reported the facility declined to permit R102 to return because of inappropriate behaviors. (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a telephone interview on 5/6/2025 at 1:50 PM, facility admission Director B reported the executive team decided not to permit R102 to return to the facility after his 3/28/2025 local hospital admission because of his behaviors. admission Director B reported communication between the facility's admissions staff and the hospital was documented in CarePort, a message center used for facility admissions staff to communicate with local hospitals. Review of R102's CarePort documentation revealed the following: 3/31/2025, 11:37 AM, local hospital staff: He is medically ready for discharge and would like to come back to your facility. Can you please take him back for a short stay? His chest tube is removed. 3/31/2025, 11:42 AM, facility Business Development Manager E: I am sorry but he is on our do not admit list. 3/31/2025, 11:42 AM, facility admission Director D: We no longer have a bed available. Does he have family that can go to the facility to gather his belongings? 3/31/2025, 11:44 AM, local hospital staff: May I ask why for his do not admit list? No, he doesn't have any family that can go to the facility to gather his belongings. 3/31/2025, 12:03 PM, facility admission Director D: He was having behaviors. We also do not have a bed available. In an interview on 5/6/2025 at 3:00 PM, the Nursing Home Administrator (NHA) reported R102 signed a bed hold refusal but there was no documentation in the medical record to explain why he was not permitted to return to a different bed. The NHA reported R102 had made inappropriate comments while at the facility but had not assaulted staff or residents. In a telephone interview on 5/6/2025 at 4:16 PM, R102 reported he desired to return to the facility and did not understand the bed hold refusal that he signed when he discharged . R102 stated, I did not know. Review of R102's Notice of Bed Hold Policy dated 3/28/2025 revealed R102's name and the date was not noted at the top of the form, the staff signature at the bottom was not legible, and the staff signature was not dated. In an interview on 5/7/2025 at 8:30 AM Registered Nurse (RN) Unit Manager F reported she signed the bottom of R102's Notice of Bed Hold Policy dated 3/28/2025 even though she did not witness R102 sign the form. RN Unit Manager F reported she noticed the form was missing information including the x marking the resident designation to not hold the bed and the staff signature. RN Unit Manager F reported she spoke to the night shift nurse to confirm R102 did not wish to hold the bed and then marked the x for the bed hold refusal and signed the form. RN Unit Manager F reported the space for the resident's name and date at the top should have also been filled out. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/7/2025 at 8:07 AM, the NHA reported the decision not to allow R102 to return to the facility after his hospitalization was made without her knowledge. The NHA reported R102 should have been permitted to return to the next available bed. The NHA stated there was no reason the facility could not meet the needs of this resident as many residents in the facility have inappropriate behaviors. In a telephone interview on 5/7/2025 at 9:08 AM, facility Business Development Manager E reported R102 did not return to the next available bed because he was on the do not admit list because of behaviors exhibited while at the facility such as yelling and hitting himself. Business Development Manager E reported she was not sure who made the decision to place R102 on the do not admit list and believed it was a miscommunication. In a telephone interview on 5/7/2025 at 9:50 AM, facility admission Director B reported R102 was mistakenly added to the do not admit list without the approval of the executive team. admission Director B reported if R102 had been deemed safe to return by the local hospital he could have returned to the next available bed, but he did not go through the onboarding process because he was on the do not admit list. Review of facility policy/procedure Transfer and Discharge, revised 3/2025, revealed .In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding the reason for the transfer or discharge will be provided by a provider . Emergency transfers to acute care . The resident will be permitted to return to the facility upon discharge from the acute care setting . Not permitting a resident to return following hospitalization constitutes a discharge. In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative before the discharge, and must also send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman .