| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235290 | A. Building<br>B. Wing | 08/22/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mission Point Nursing & Physical Rehabilitation Ce | 828 East Washington Street<br>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 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<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 0689<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 2576436Based on interview and record review, the facility failed to ensure the safety and well-being of one Resident (R101) of three residents reviewed for supervision.Findings include: Review of the admission Record reflected R101 originally admitted to the facility 8/5/2019. The Electronic Medical Record (EMR) reflected pertinent diagnoses that included severe morbid obesity, dependance on wheelchair, heart failure, cardiomyopathy, and diabetes mellitus. The medical record reflected the Resident was his own responsible party.On 8/21/2025 at 10:01 AM an interview was conducted with R101 in his room. R101 reported that on the night of 7/28/2025 at about 11:00 PM Licensed Practical Nurse (LPN) H let him outside to the facility interior courtyard in his power wheelchair so he could water his tomatoes. R101 reported LPN H was to come out shortly to help him but never came outside. R101 reported he attempted to turn off the water and return to the building, but his power wheelchair got stuck in mud. R101 reported he cannot walk so he called out repeatedly and attempted to gain attention by spraying water at resident room windows. R101 reported about five hours later, around 4:00 AM he was found by Certified Nurse Aide (CNA) D. R101 reported that a walker was brought out to him so he could stand and support himself while two CNA's freed his powerchair from the mud. On 8/22/2025 at 12:36 PM a telephone interview was conducted with LPN H. LPN H reported on the night of 7/28/2025 R101 let himself out to the facility interior courtyard about 11:45 PM. LPN H reported R101 wanted her to come out, but she had told him she was really busy and may not be out. LPN H reported she had seen the Resident outside alone in the courtyard on previous occasions and that, while residents were not supposed to know the door key code, R101 must have known the code. LPN H reported she was not concerned as it was an interior courtyard. LPN H reported she had checked R101's room several times during the night but that it was not unusual to not see him in his room or during the night. LPN H reported R101 was part of a small group of residents up during the night that would sign out to go smoke or watch television in a common area. LPN 'H' reported about 4:00 AM she still had not seen the Resident and asked staff to look for him. LPN H reported the Resident was found by CNA D in the facility courtyard in his power wheelchair which was mired in the mud. LPN H reported a walker was taken out to the Resident and staff stood with him while the power wheelchair was pushed out of the mud.On 8/22/2025 at 12:16 PM a telephone interview was conducted with CNA D. CNA D reported on the morning of 8/28/2025 she had not seen R101 for a long time which was not unusual for the Resident. CNA D reported R101 didn't usually stay in the facility during the night and would sign himself out to smoke with a couple of other residents. CNA D reported she started looking for R101 sometime after 3:30 AM. CNA D reported the staff near the facility exit reported that R101 had not gone outside and that was when she checked the interior courtyard. CNA D reported she found R101 in his power wheelchair stuck in the mud in the courtyard. CNA ‘D reported that R101 was upset and had complained that he had been in the courtyard for for hours despite yelling out. CNA D reported R101 had a phone with him but that the phone was not functioning. CNA D reported the Resident's walker was retrieved and he stood by while staff pushed his power wheelchair out of the mud. Review of the EMR Progress Notes for R101 reflected an entry dated 7/29/2025 at 4:15 AM by LPN H. The entry reflected, resident (R101) was found in the courtyard stuck in his electric wheelchair in the mud, he had been out watering the garden and tried to shut off the water when he got stuck, no injuries. During an interview conducted 8/22/2025 at 7:30 AM, Unit Manager (UM) J reported if a resident leaves the building, they or their guardian are required to sign out in the books that are on the unit or at the front door. UM J reported staff do hourly rounds on residents and can check the books to see if a resident had left the facility.During an interview conducted 8/22/2025 at 7:21 AM Registered Nurse (RN) B reported that residents are coded out of the building by staff. RN B reported that if a resident cannot be accounted for the Elopement protocol is initiated and a head count is conducted. RN B once all residents are accounted for an all clear is announced overhead.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Health care agencies have instituted purposeful hourly rounds to improve nurse responsiveness and patient satisfaction. Purposeful rounds include the 4 Ps (i.e., pain, potty, positioning, and periphery). Nursing staff usually conduct hourly rounds and ask patients about their pain and whether they need to toilet; then the patients are positioned for comfort, and an environmental check is done. The implementation of purposeful rounding improves patient safety by decreasing the occurrence of patient preventable events and proactively addresses problems before they occur (Zadvinskis et al., 2019). [NAME], [NAME] A ; [NAME], [NAME] G ; |