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	12/10/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2645718 and 2619157. Based on interview and record review the facility failed to implement ordered wound treatments for 1 resident (R5) of 3 residents reviewed for wound care. Findings include:Review of an admission Record revealed R5 admitted to the facility on [DATE] with pertinent diagnoses which included diabetes, a pressure ulcer, and muscle weakness. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R5, with a reference date of 10/20/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R5 was cognitively intact. In an interview on 12/10/2025 at 9:35 AM, R5 reported staff do not always complete her dressing changes. Review of R5's Treatment Administration Record (TAR) revealed the following dressings not marked as completed by nursing staff- September 2025-Right Lower Anterior Leg- incomplete on 9/13/2025Wound #1 Right Buttock- incomplete on 9/11/25, 9/12/2025, and 9/13/2025 October 2025-Right Lower Anterior Leg- incomplete on 10/1/2025, 10/11/2025, and 10/19/2025Wound #5 Right Buttock- incomplete on 10/10/2025, 10/11/2025, 10/14/2025, 10/18/2025, 10/19/2025, and 10/20/2025Wound #6 Left Shin- incomplete on 10/18/2025, 10/19/2025, and 10/20/2025 November 2025-Wound #5 Right Buttock- incomplete on 11/7/2025, 11/11/2025, and 11/21/2025 In an interview on 12/10/2025 at 9:59 AM, the Director of Nursing (DON) B reported she could find no documentation that R5's dressings on 9/11/2025, 9/13/2025, 10/10/2025, 10/11/2025, or 10/14/2025 were completed or refused. DON B reported all ordered dressings should be marked on the TAR as either completed or refused. Refused dressing changes should have a corresponding progress note explaining the circumstances of the refusal.

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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	235290	A. Building B. Wing	12/10/2025

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Mission Point Nursing & Physical Rehabilitation Ce	828 East Washington Street Greenville, MI 48838

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	235290	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to implement care plan interventions, standards of care for safety with transfers, and positioning and wheelchair equipment for 1 Resident (R6) of 3 residents sampled for accident hazards.This citation pertains to intake 2619157Review of R6's admission record dated 12/9/25 revealed he was a [AGE] year-old male admitted to the facility on [DATE] with diagnoses that included dementia, chronic pain syndrome, left hip prosthesis, intracranial injury (brain injury), and muscle weakness. R6 was not his own responsible party.Review of R6's care plan revealed a care plan for alteration in musculoskeletal status r/t (related to) left hip dislocation (most recent 11/29/25, 12/3/25 and 12/6/25) with knee immobilizer brace in place at all times per ER (emergency room) doctor. I see an orthopedic provider on 12/10 who is going to see if I am a candidate for surgery dated revision on 12/09/25. Interventions added 12/9/25 included, L (left) posterior hip precautions (no bending L (left) hip past 90 degrees, no crossing legs, and no inward rotation of the L (left) leg). Place pillow between patient legs in supine position as tolerated. pt (patient) is WBAT (weight bearing as tolerated) to LLE (left lower extremity) with knee immobilizer donned at all times. pt (patient) is limited 1 assist with sit to stand transfer to WC (wheelchair) as pt allows/tolerates. Review of R6's ADL (Activities of Daily Living) care plan dated revision on 12/9/25 revealed, Transfer - limited assist X 1 with sit to stand transfer to WC (wheelchair) as pt (patient) allows/tolerates. Ensure knee immobilizer is in place and left hip is supported during transfer.Review of R6's fall care plan dated revision on 12/09/25 revealed interventions that included: ensure I go to dining room for all meals (initiated on 8/13/25). R6 was observed in bed on 12/9/25 at 8:45 AM. R6 was struggling to cut his pancakes with a spoon, he had 3 sausage links on his plate that were not cut. He had not eaten any of the pancakes or sausage and he had a full bowl of cereal. There were no staff in the area to assist him. R6 was asked if he had any falls in the facility and he said, yes. R6 could not recall when he fell or what had happened. R6 pointed to his left leg and said it was not right. R6's toes on the left foot were turned inward, he tried to push his left foot with his right foot but couldn't make his left foot turn. (see care plan above, he was care planned to eat in the dining room due to fall risk and required cueing for eating).R6 was observed in bed on 12/9/25 at 3:08 PM. R6 had a 4 wheeled walker with a seat next to his bed. The seat had 2 standard wheelchair footrests on the seat. Physical Therapist (PT) H was in the room and was asked about R6's care and mobility. PT H said R6 fell on Thanksgiving when he was home with his family, he had a history of left hip dislocations and dislocated it again on Thanksgiving and at least one time since Thanksgiving. PT H said while they are waiting for a custom leg brace R6 is to use the knee immobilizer at all times, and he is currently not walking. PT H said the wheelchair in the hall belonged to R6 and the leg rests on the walker were for his chair. The left leg rest would not be able to support R6's leg properly in the wheelchair as it did not extend or have calf pad. PT H was not aware R6's did not have a proper leg rest for his left leg when he was up in his wheelchair. Unit Manager (UM) I was asked about resident safety needs like being in the dining room for meals and a supportive wheelchair footrest. UM I said R6 went to lunch but was not sure who took him or why he did not have the proper leg rest. She confirmed R6's walker was not to be left at his bedside, and she did not know why he did not go to breakfast.R6 was observed sitting on the edge of his bed on 12/10/25 at 7:20 am. R6's breakfast tray was on his bedside table. Certified Nurse Aide (CNA) F was getting ready to put R6 in his wheelchair. CNA F instructed R6 to stand and turn into his wheelchair. CNA F held onto R6's pants. R6 used his left hand on his bedside table (table on wheels) to support himself as he turned. CNA F struggled to get R6's left leg rest adjusted on his wheelchair. She placed the leg rest in the longest position, and it was still about 8 inches short. The only way his leg could fit on it was to turn the foot plate out of the way. R6 foot did not have support, and his left leg was turned inward. (R6 was care planned to use a sit to stand lift for transfers).During an interview was with CNA F on 12/10/25 at 7:35 AM, CNA F was asked for the reason she did not use a gait belt with R6 when she transferred him to his wheelchair, and she said she did not see one. She looked back into R6's room and found one on the wall. CNA F was asked why R6 ate his breakfast in bed, and she said he was on bedrest most of the time now. CNA F was asked if bedrest was care planned and if he was care planned to eat in the dining room and CNA F said she did not read his care plan today. Review of R6's progress note dated 12/9/25 at 17:06 (5:06 PM) revealed, RN (Registered Nurse) provider and therapy reviewed resident's plan for his recent left hip dislocations. Therapy has updated the recommendations for the residents. Staff is aware and there was a teach and sign performed so that all staff