STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235357	A. Building B. Wing	09/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	414 E State Street Belding, MI 48809

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2626738Based on observation, interviews and record review, the facility failed to protect the resident's (R4's) right to be free from physical abuse by another resident (R3), resulting in physical and psychosocial harm to R4. Findings:Resident #3 (R3)Review of an admission Record reflected R3 admitted to the facility on [DATE] with diagnoses that included unspecified dementia with behavioral disturbances, anoxic brain damage, chronic obstructive pulmonary disease, anxiety, insomnia, and a personal history of sudden cardiac arrest. Review of a comprehensive Minimum Data Set (MDS) assessment dated [DATE] reflected R3 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status score of 8/15. The assessment did NOT indicate whether R3 exhibited wandering behavior or was intruded on the privacy or activities of others. Section F - Preferences for Customary Routine and Activities reflected it was 1 - Very important to have books, newspapers, and magazines to read, listen to music you like, keep up with the news, do things with groups of people, do your favorite activities, go outside and get fresh air when the weather is good and participate in religious services or practices.Review of a Care Plan initiated on 9/5/2025 reflected (R3) am at risk for elopement. I am a wanderer, and exhibit Exit seeking behavior r/t (related to) History of successful attempts (to) leave previous facility unattended. I am independent with mobility without a physical device, I have a diagnosis of dementia/other cognitive problem, I have impaired safety awareness. I wander the unit the majority of the day, lack personal boundaries, and enter other resident's personal space. I wander in-and-out of other resident rooms and have a history of getting into their personal belongings. On 9/09/2025, the facility initiated an intervention Distract me from wandering by offering pleasant diversions; I prefer listening to music, ‘slow jams' and playing cards.Further review of the Care Plan, initiated on 9/5/2025 reflected that R3 has impaired cognitive function or impaired thought process related to dementia diagnosis and anoxic brain injury. I have impaired cognitive function or impaired thought process r/t Dementia diagnosis. I have the potential to demonstrate physical behavioral/verbal frustration related to dementia (impaired personal boundaries, defending my personal space, believing others to be in my home, etc.) I may not be invited to attend my care conference (with family and/or guardian), as my cognition is impaired, and my mood/behavior may escalate r/t talking about placement, behaviors, need for assist, etc. Review of a Nursing Progress Note dated 9/7/2025 at 1:12 PM reflected R3 was Pacing and exit seeking entire shift. Was using his roommate's phone. Attempting to call taxi. Continues to go door to door and checking to open. Repeatedly stated that he is not staying here.Review of Behavior Notes dated 9/7/2025 at 9:13 PM reflects Resident pacing all shift trying to get out of the unit nonstop. Resident using roommates' phone to call for rides and ask for drugs. Resident not allowing staff to take urinated clothes out of room. Resident increased yelling and aggressive behavior we (sic) staff asked for clothes to be cleaned. The Intervention to address the behavior was to explain how laundry works at the facility and was not effective in relieving R3's aggressive behavior. The note included space to document physician notification as well as what interventions were put into place to keep others safe. Both areas in the Behavior Note were left blank. Review of a Nursing Progress Note dated 9/11/2025 at 8:25 PM reflected R3 had exit seeking behaviors from onset of shift until dinner time . (R3) was attempting to open several doors including other resident's rooms. He was easily redirected. The note does not specify how or what R3 was redirected to do. Review of a Nursing Progress Note dated 9/12/2025 at 11:18 PM reflected (R3) with wandering, exit seeking and attempting to take others' items. Redirected easily by staff but increased verbal confrontations with other residents upon entering rooms. The progress note did not specify the residents R3 is having increased verbal confrontations with or what items R3 is trying to take. Review of a Incident Note dated 9/13/2025 at 8:13 PM reflected This resident was involved in a physical altercation with another resident @ (at) 1525 (3:25 PM) on 09/13. This resident (R3) entered another resident's room, made physical contact with the other resident's left cheek with a closed fist. Immediately separated, placed on 15-minute checks. Appropriate parties notified. Immediate intervention implemented: 15-minute checks.Resident #4 (R4)Review of an admission Record reflected R4 admitted to the facility on [DATE] with diagnoses that included bipolar disorder, frontotemporal neurocognitive disorder, schizoaffective disorder, psychoactive substance-induced persisting dementia, muscle weakness, primary open angle glaucoma, bilateral and chronic pain. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R4 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 12/15. Review of a Care Plan

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2626738Based on observation, interview, and record review the facility failed to thoroughly investigate resident-to-resident abuse for two residents (R3 & R4).Findings include:Resident #3 (R3)Review of an admission Record reflected R3 admitted to the facility on [DATE] with diagnoses that included unspecified dementia with behavioral disturbances, anoxic brain damage, chronic obstructive pulmonary disease, anxiety, insomnia, and a personal history of sudden cardiac arrest. Review of a comprehensive Minimum Data Set (MDS) assessment dated [DATE] reflected R3 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status score of 8/15. Review of a Incident Note dated 9/13/2025 at 8:13 PM reflected This resident was involved in a physical altercation with another resident @ (at) 1525 (3:25 PM) on 09/13. This resident (R3) entered another resident's room, made physical contact with the other resident's left cheek with a closed fist. Immediately separated, placed on 15-minute checks. Appropriate parties notified. Immediate intervention implemented: 15-minute checks.Resident #4 (R4)Review of an admission Record reflected R4 admitted to the facility on [DATE] with diagnoses that included bipolar disorder, frontotemporal neurocognitive disorder, schizoaffective disorder, psychoactive substance-induced persisting dementia, muscle weakness, primary open angle glaucoma, bilateral and chronic pain. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R4 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 12/15. Review of a Facility Reported Incident (FRI) reported to the State Agency (SA) on 9/13/2025 reflected the Nursing Home Administrator (NHA) was notified at approximately 3:30 PM of an alleged resident to resident incident between R3 and R4. Licensed Practical Nurse (LPN) A was called to R4's room and found R3 in R4's room with coffee spilled on the floor. Both residents claimed to be hit by the other residents. Residents were immediately separated. Brusing and a small skin tear noted to R4's left side of face. Neurological assessments started and every 15-minute checks implemented. Provider called for medication review. Mental health provider to see both residents and social work to follow up. NHA, Director of Nursing (DON), On-Call Provider, and local law enforcement notified. Further review of the full investigation report did not include statements from staff who had been working with R3 in the hours leading up to the incident. The investigation did not include statements from the nurse aides who were on duty at the time of the incident. There is no evidence in the investigation there were any visitors on the unit or employees on duty on the unit at the time of the occurrence who may have been a witness to the circumstances leading up to the event. During an interview on 9/24/25 at 3:40 PM, the NHA was asked if there were any additional witness statements to be included in the FRI pertaining to R3 and R4. The NHA contacted Registered Nurse (RN) (a unit manager) M, the Director of Nursing (DON), the Administrator in Training (AIT) P, RN E (the manager for the unit where R3 and R4 live). The NHA reported there were no additional witness statements. During an interview on 9/25/25 at 1:12 PM, Certified Nursing Assistant (CNA) J reported that she was working on the unit where R3 and R4 lived at the time of the event on 9/13/25. CNA J reported no one had asked her to provide a statement about the resident-to-resident abuse. During an interview on 9/25/25 at 1:43 PM, CNA B reported she worked the day shift on 9/13/25 the day of the incident between R3 and R4. CNA B reported she had not been asked to provide a statement pertaining to the resident-to-resident abuse between R4 and R3 on 9/13/25. During an interview on 9/25/25 at 2:35 PM, LPN A reported that she was working on the S2 unit on 9/13/25 at the time of the incident between R3 and R4. LPN A was not asked to provide any additional information for the investigation into the resident-to-resident abuse between R4 and R3 other than what is documented in the clinical record. During an interview on 9/26/25 at 9:00 AM, CNA D reported that she was working on the S2 unit on 9/13/25 at the time of the incident between R3 and R4. CNA D reported she was not asked to provide a statement for the abuse investigation. During an interview on 9/26/25 at 10:45 AM, RN F reported that she worked on the S2 unit the first shift on 9/13/2025. A statement from RN F was not included in the investigation report. RN F reported there were no activities happening that day. Review of the facility policy Abuse, Neglect and Exploitation last reviewed/revised 10/2024 reflected A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. The policy specified, .4.Idetifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; 5. Focusing the investigation on determining if abuse, neglect, exploitation and/or mistreatment

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2626738Based on observation, interview and record review, the facility failed to ensure it provided a meaningful activity program for cognitively impaired residents living on the locked unit and 2 residents (R3 and R4) out of 7 sampled residents reviewed.Findings:During an observation on 9/24/25 at 10:45 AM, 1 activity assistant was observed in the South 1 dining room on the locked unit at the facility painting the fingernails of a resident. There were 15 other residents in the dining room. None of the other residents were engaged in an activity. No other staff were present in the dining room to engage or assist with the residents. During an observation on 9/24/25 at 10:51 AM, 4 residents were sitting in the South 2 dining room. A television was on, no activities were happening at this time. During an observation on 9/24/25 beginning at 11:05 AM, no activity calendars were posted in the hallways, in common areas, in dining or activity rooms, near nurse stations or in resident rooms on the South 1 or South 2 units announcing what activities were planned for the week or month. During an observation on 9/24/25 at 1:31 PM, a large sign for Activities of the Week is hanging in the hall outside a day room on the North Unit. The weekly calendar is blank; no activities are posted in the sleeves on the sign. During an observation on 9/25/25 beginning at 11:10 AM, 10 residents were in the dining room on the South 1 dining room on the locked unit. A television was on, but residents were positioned around tables that were not facing the television, none of the residents were engaged in an activity. At 11:30 AM another resident wandered into the dining room. A staff member entered the dining room and wheeled dirty dishes on a cart out of the room but did not speak to the residents. Another staff member entered the dining room and retrieved an item from a cupboard but did not engage with any of the residents in the dining room. Staff began wheeling residents into the dining room in preparation for the noon meal, never stopping to engage with the residents who were sitting in the dining room. By 12:00 PM, 17 residents were in the dining room. Almost one hour had gone by without meaningful activity or engagement between residents or from any staff members. During an observation on 9/25/25 at 12:13 PM, LPN K reported that there was not an activity happening on the South 2 unit. LPN K said that sometimes there would be a few higher functioning residents that could go to the North Unit and participate in some of the activities with the residents that live there, but that it doesn't work for everyone that lives on the locked unit. During an observation on 9/25/25 at 3:10 PM, a whiteboard outside a dining room on the North Unit indicated that a game of Skip-Bo was to be played at 3:00 PM in the dining room. The dining room door was closed, and the room was dark, no activity was taking place. During an interview on 9/25/25 at 3:40 PM, the Activity Director (AD) C reported that she was not aware that the card game was not being played, then recalled that her part-time staff member had worked her hours that week and needed to leave before the activity was scheduled. AD C was needed to supervise a resident who was at risk for falling and needed a 1:1 for supervision, therefore the activity did not happen. AD C reported she did not have enough staff to manage two full activity calendars, one for the dementia unit (locked, South unit) and the North unit for the more cognitively intact residents. When asked, AD C said there would be no way of telling by looking at the activity calendars which activities were carried out and which ones had to be cancelled. AD C said I have tried to integrate cognitively impaired residents with the cognitively intact residents, but it really doesn't work, it's a constant back and forth. Staffing makes all the difference. When asked, AD C reported that nearly half of the 102 residents living at the facility lived on the locked South units. Resident #4 (R4)Review of an admission Record reflected R4 admitted to the facility on [DATE] with diagnoses that included bipolar disorder, frontotemporal neurocognitive disorder, schizoaffective disorder, psychoactive substance-induced persisting dementia, muscle weakness, primary open angle glaucoma, bilateral and chronic pain. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R4 was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 12/15. Review of a Care Plan Focus identified on 5/8/2023 indicated (R4) have the potential to demonstrate behaviors verbally i.e., to talk to myself and have the potential to use inappropriate language and potential for verbal frustration/agitation r/t dementia and mental illness. Profanity is often a part of my everyday vocabulary. I have the potential to become behavioral when I am not having my wants met immediately, I have the potential to become behavioral r/t (related to) guardianship and desire to discharge. I appear to be talking to or seeing things/people that are not there. I have potential to make false accusations. An intervention initiated 2/6/2023 included Analyze key times, places, circumstances, trigger, and what de-escalates behavior and document