STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2584838.Based on observation, interview and record review, the facility failed to protect Resident 101 (R101) and Resident 102 (R102)'s rights to be free from verbal and physical abuse and Resident 103 (R103) and Resident 104 (R104)from physical abuse during two resident-to-resident altercations, for four (R101, R102, R103, R104) of four residents reviewed for abuse, resulting in the potential for feelings of disrespect for R102; fear of an impending threat for R104 and an emergency room (ER) visit for R101 and R103 related to injuries sustained during the resident-to-resident altercations. Resident #103: A record review of the Face sheet and Minimum Data Set, indicated Resident #103 was admitted to the facility on [DATE] with diagnoses: History or a stroke, dementia, diabetes, right and left leg amputations below the knee, acquired absence of right fingers, peripheral vascular disease, neuropathy, depression, rosacea, folliculitis (a skin condition), adjustment disorder with mixed disturbance of emotions/conduct, mild cognitive impairment and alcohol abuse. The resident was discharged to the hospital emergency room on 8/11/2025. A review of the progress notes for Resident #103 identified the following: 8/11/2025 at 4:35 PM, a nursing progress note, “Resident observed in the main lobby of the first floor with a bag of medications. Explained to resident that he could not have the medication in his room and they would need to be given to the nurse. Resident became very agitated and attempted to swat at writer with his hand… Medications taken from the resident and placed on the floor with nurse.” 8/11/2025, a late entry for 4:58 PM, a nursing progress note, “UM (unit manager) retrieved a bag of medications from resident after coming in from an LOA (leave of absence) to assist with verifying the medication with the physician and floor nurse.” On 8/11/2025 at 5:12 PM, an “Interact SBAR Summary for Providers” assessment document listed the following: “Situation: The Change In Condition reported on this (assessment) are/were: Skin wound or ulcer (not specified); At the time of evaluation resident/patient vital signs, weight, and blood sugar were: (The blood pressure, pulse respiratory rate and Temperature were all dated 6/27/2025). Weight was 137 lbs. dated 7/1/2025 and there was no blood sugar recorded. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	Most of the questions were blank on the “Interact SBAR Summary for Providers” assessment dated [DATE] except for the “Nursing observations, evaluation, and Recommendations are: Resident was involved in an altercation with another resident resulting in injuries to left eye, and lip…. Provider ordered resident to be monitored…” On 8/11/2025 at 5:27 PM, a Discharge Emergent Note revealed, “Was a physician order obtained for transfer/discharge? ‘Yes’; What is the reason for resident transfer/discharge? ‘Evaluation post incident/altercation.” A review of the Care Plans for Resident #103 included the following: Behaviors: I have a history of leaving facility and being gone all day, come back intoxicated I have been verbally inappropriate with staff; I recently was observed intoxicated coming back to the floor and physically aggressive with staff…” date initiated 12/18/2024, revised 3/13/2025 with Interventions including: “Increase my supervision when observed to be intoxicated/under the influence as needed,” date initiated 6/5/2025. “I have (moderate/severe) impaired cognitive function or impaired thought processes related to dementia diagnosis,” date initiated 12/18/2024 with Interventions including: “Report to Social Services and Nurse any changes in cognitive function, specifically changes in: decision making ability, memory, recall and confusion,” date initiated 12/18/2024 and revised 1/9/2025. “I have the potential for mood difficulties and/or adjustment concerns related to (diagnosis) depression, ” date initiated and revised 12/18/2024 with Interventions including: “Provide me with Behavioral health consults as needed,” date initiated 12/18/2024. All of the Care Plans were discontinued on 8/19/2025 after the resident was discharged . On 8/20/2025 at 1:30 PM, during an interview with the Administrator and Director of Nursing, the Administrator said Resident #103 and Resident #104 had an incident where both of them were physically aggressive with each other. Resident #103 had a swollen left eye with a laceration and his lip was bleeding and Resident #104 had a red mark on his chest, his shirt was stretched out of shape, and he had a red mark on his cheek. The Administrator said Resident #103 was transferred to the hospital and did not return. She said Resident #103 smelled like he had been drinking alcohol at the time of the incident and had a history of alcohol abuse. The Administrator said Resident #103 had returned to the facility from picking up his medications from the pharmacy prior to the incident. The Administrator said Resident #103 did not return to the facility after transferring to the hospital on 8/11/2025. Resident #104 continued to reside at the facility. Resident #104: A record review of the Face sheet and Minimum Data Set/MDS indicated Resident #104 was admitted to the facility on [DATE] with diagnoses: Paraplegia, history of physical injury/gunshot, nerve pain, and peripheral vascular disease. A review of the progress notes for Resident #104 identified the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	8/12/2025 at 2:34 PM, a nursing progress note provided, “Impaired Skin Integrity was documented. Resident has no open areas noted. Skin is intact. Resident has some scratches/redden area to his right cheek and chest area.” There was no mention in the progress notes of the incident between Resident #103 and Resident #104, or that Resident #104 hit Resident #104 in the face on 8/11/2025, until 8/14/2025. 8/14/2025 no time documented, a general note, “Attempted to see pt (patient) due to need for re-sending of controlled substances and due to hx (history) of altercation with another resident. Pt is LOA (leave of absence) from the facility at this time…” A Late Entry Practitioner note dated for 8/15/2025 at 6:47 PM provided, “… Patient had an altercation with another resident. No acute injuries… He self-propels his wheelchair and independently performs his ADL’s (activities of daily living) and transfers. Over the past 60 days has had no falls or hospitalizations: however, episodes involving in-room vaping and verbal altercations with another resident have been documented… Residential institutional living problems; Chronic/unstable. Counsel on appropriate in-facility behavior, Monitor interactions with peers, Encourage positive coping and recreational participation. 8/18/2025 at 10:23 AM, a Nursing Incident note, “Report Type: Incident/Accident, Description of what occurred: Resident received physical aggression from another resident. Immediate Intervention implemented: separated resident’s.” On 8/20/2025 at 2:30 PM, Resident #104 was interviewed. He said he was involved in an incident with Resident #103. Resident #104 said he was trying to sign out at the reception desk on the 1st floor to go outside, when he heard a commotion by the doors. He said some nurses were telling Resident #103 that he couldn’t have his bag of medications and they were trying to take them from him. He said Resident #103 became very upset and was yelling. Resident #104 said the nurses took the medications and went into the conference room and shut the door. He said Resident #103 continued to yell and wave his arms. Resident #104 said he was trying to go towards the front door to go out and Resident #103 “got into his space”. He said he told Resident #103 to “get out of my way” and Resident #104 stated, “He grabbed my shirt. I pushed him back away and he started swinging his arms. I defended myself. I just punched. Staff came out and broke it up. The police came.” Resident #104 was asked if he had been involved in any other incidents at the facility and he said no, but he said he felt vulnerable being in a wheelchair and if someone tried to come at him he would defend himself again. Resident #104 was asked if he would hit someone again and he said he would if he felt threatened. A review of the Care Plans for Resident #104 identified the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	“I have potential to demonstrate behaviors verbally inappropriate and interjecting myself into others conversations related to ineffective coping skills, Mental/Emotional illness, Poor Impulse control… I will inform staff or leadership of any inappropriateness from anyone and not attempt to take matters in my own hands…” date initiated 7/14/2024 and revised 6/23/2025, with Interventions including: “Staff to document my observed behavior and attempted interventions on my POC (plan of care), ” date initiated,” date initiated and revised 7/14/2024; “When I become agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive, staff to walk calmly away, and approach later,” date initiated 8/26/2024 and revised 6/16/2025. The Care Plan had not been reviewed or revised after Resident #104 had an altercation with Resident #103 and Resident #103 was transferred to the hospital. A review of the Facility Reported Incident/FRI dated 8/11/2025 involving Resident #103 and Resident #104 was reviewed. The “Summary of incident,” included the following: “The administrator was informed that resident #1 (Resident #3) and resident #2 (Resident #104) were involved in a physical confrontation in the lobby area. Resident #1 was in the lobby vociferously shouting and verbally menacing the staff. When Resident #2 attempted to exit, he requested Resident #1 to vacate the doorway, as he was obstructing it, and to refrain from bothering this writer and the staff. Resident #1 invaded the personal and facial space of resident #2, refusing to withdraw, and began speaking rapidly, causing saliva to project towards resident #2’s face. He then extended his hand to push resident #2 away, resulting in mutual physical contact between them… The facility contacted 911 to request assistance from the police… Officers: The resident #1 is recommended to go to hospital as he refuses to allow the facility nursing staff to assess him A review of a “(facility) Interview Form” dated 8/11/2025 for an interview with Resident #104 and written by Nurse “J” provided the following, “I came out of the main dining, receptionist asked me to sign out. As I got to the clipboard to sign out, I saw (Resident #103) and he seemed agitated and I told him to back up and get out of my personal space and put my arm up to keep him away. (Resident #103) then spit as he was talking and kept coming towards me and then we had an altercation. ” A review of a “Statement” from Resident #103 written by Nurse “J” dated 8/11/2025 provided, “Resident was entering the building with his medication from (the pharmacy) to take to the floor and Unit managers stopped him stated “We need to take those medications, and you can not have those.” The other resident came out of the dining room and hit me. I tried to rip his shirt off.” On 8/18/2025 the facility provided “De-escalation Training” for staff beginning 8/18/2025 and continuing through 8/20/2025. There was no identification of education or counseling for Resident #103 or Resident #104 related to their aggressive and combative behaviors. Resident #104 received visits from the facility Social Worker to see how he was coping, but there was no mention of his aggressive behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/2025 at 9:40 AM, Nurse Manager “K” was interviewed about the altercation between Resident #103 and Resident #104 and stated, “I didn’t see the incident. I was in here (the conference room) doing some work. When I came out the residents were separated. One staff member had (Resident #103) and one had (Resident #104), someone said they hit each other. (Resident #103) his face was red his eye swollen; (Resident #104) had redness on his chest and cheek. His shirt collar was stretched out like someone had been pulling his shirt. (Resident #103) had some blood on his lip or nose.” Nurse Manager “K” was asked if Resident #103 had talked to the Nurse Manager’s before the incident and stated, “We had been getting off the elevator and he had just came back from LOA/leave of absence and he had a bag of medications, and we said ‘You can’t take them up to your room. You have to give them to the nurse, and they will give them to you.’ I can’t remember who reached for the medications first, but I ended up with them. We told him he could take them to the nurse, and he said, ‘No’. He was upset when someone reached for them. He let us get the meds. Then he wheeled towards the elevator. I didn’t see exactly where he went. We came back in here (the conference room). Afterward, we called the Police. They interviewed him and said he needed to go to the hospital because he needed to receive treatment because of his injuries.” During an interview with Nurse Manager “J” on 8/21/2025 at 10:03 AM, she stated “Initially when the incident happened, I was in here (conference room), Me (the DON, and Nurse Manager “K”). We were packing up to leave. When he (Resident #103) came through the door we talked to him because he had his meds in a pharmacy bag. He did not have a self-administration (ability to self-administer his own medications). He was intoxicated. You could smell it and he told us he had a drink. I usually go up and get them from the pharmacy for him. This was a new order, and he was anxious to get them and did not want to wait. He kept saying something about it days prior and he asked me about it. It was a dermatology order. He becomes really headstrong about his dermatology appointment. He gave them to (Nurse Manager “K”). We came back in the conference room and got ready to go and heard he had a scuffle with (Resident #104). (Resident #104) had some redness to his chest, [NAME] marks on his face. (Resident #103’s) face was red, lip, eye red and swollen. I think his lip was bleeding. When he drinks he gets belligerent to staff. When he was sober he was the perfect resident.” Nurse Manager “J” was asked if other residents drank alcohol outside the building and she stated, “Some other residents drink outside and come back, some get drunk. Usually when we are not in the building.” Nurse Manager “J” was asked if Resident #103 went to the hospital after the incident and she stated, “He wanted to go to the hospital. The ambulance came here with the police. ” On 8/21/2025 at 10:30 AM, the Director of Nursing/DON was interviewed, and said she was in the conference room with Nurse Managers “J and K” when she heard a commotion in the hall. She said staff were pulling Resident #103 and #104 apart from each other in their wheelchairs. On 8/21/2025 at 10:59 AM, the Administrator was interviewed about the incident between Resident #103 and Resident #104 and said she was not aware of the incident until she left the day room and entered the hall and the DON said there had been an altercation between the residents. The Administrator said she interviewed both residents. She said Resident #103 was very upset and she tried to calm him down. She said both residents said they hit each other. The Administrator said Resident #103 had swelling around his left eye and some bleeding on his face. She said the police came and interviewed the residents. She said there was no police report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	During the interview with the Administrator on 8/21/2025 at 10:59 AM, reviewed with her the conversation this surveyor had with Resident #104, and he said he would hit again if he felt threatened. The Administrator was asked what interventions were in place to prevent the altercation from happening between Resident’s #103 and #104, as both residents had a history of aggressive behavior verbally or physically, prior to the incident and Resident #104 said he would do it again. She said Resident #104 was seen on 8/12/2025 by a psychiatric practitioner, this was prior to the resident saying he would hit again; the Administrator stated, “We are going to continue to round, if we see something we are going to jump in, it is our plan to keep everyone safe. We offered ‘De-escalation’ techniques for everyone. ” Social Worker “E” was interviewed on 8/21/2025 at 1:42 PM about the incident between Resident #103 and #104. She said she did not see it and heard about it the next day. She said she did not speak to Resident #103 about the incident because he did not return from the hospital. The Social Worker said she had met several times with Resident #104, and he said he felt safe in the building. She said she referred Resident #104 to the psychiatric practitioner, and he saw someone once on 8/12/2025. She said she was not aware that the resident said he would hit someone again, if he felt threatened; but she said she understood why he said that. She was asked if the resident received education related to not hitting other residents, as most also use a wheelchair and are vulnerable and some have dementia, confusion or mental illness. The Social Worker said she thought education had been provided for some residents last year. She provided a copy of an undated document indicating Resident #103 had been talked to about inappropriate behavior, but there was nothing for Resident #104. A review of the hospital records for Resident #103 identified the following: 8/11/2025 at 6:00 PM, “Chief Complaint: Assault Victim: Pt (patient) states he was assaulted by someone, unsure who and was hit in face, has swelling and small lac (laceration) to left orbit (eye). Positive ETOH (alcohol) and smells of urine… Presents with soft tissue swelling and abrasion to the left cheek… He is clinically sober… Patient was asking for something to eat and drink which were provided… the patient reported that he had been assaulted by another resident (at the facility) … He stated his wheelchair and personal belongings remain at (the facility), but he is unable to return there and is unsure why, given that he was the one assaulted. (Social Worker) contacted (the facility) and spoke with staff member, who reported that the patient voluntarily discharged himself due to an unwillingness to follow facility rules…” A record review for Resident 101’s (R101) quarterly Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score of 3 that indicated severe cognitive impairment and indicated a need for comprehensive assistance and specialized care approaches. Further record review of R101’s medical record revealed, medical diagnoses that included: Schizophrenia (a mental health condition that affects thinking abilities, memories, and senses often have hallucinations, delusions and disorganized thinking), vascular dementia, Schizo-affective bipolar type (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania. Hallucinations involve seeing things or hearing voices that others don't observe. Delusions involve believing things that are not real or not true), asthma, heart failure and general weakness. R101 was admitted to hospice services on 06/11/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	A record review for Resident 102’s (R102) quarterly MDS assessment revealed and a BIMS score of 8, indicated moderate cognitive impairment and may need additional support and monitoring. Further record review of R102’s medical record revealed medical diagnoses included: Schizo-affective bipolar type, stroke, dysphasia (partial impairment of various aspects of communication of speech, comprehension, reading and writing), congestive heart failure, anxiety, depression and trauma related to military history. According to a record review of the facility reported incident (FRI) 5-day investigation summary, “(R101) was seated on the bed of his roommate, (R102) upon entering the room. (R102) repeatedly requested that (R101) vacate his bed but (R101) declined to comply after several appeals. (R102) reported that (R101) struck him in the facial area with the Bible and stated, “God told me to tell you that you are a nigger”. (R102) stated that he extended his arm to retrieve a shoehorn, and upon raising it up for self-defense, (R101) abruptly rose from his bed and moved away, resulting in contact with the top of his head, which caused a laceration. According to (R102), (R101) fell to the ground while in a hurry to exit the room”. A record review indicated that R101 and R102 were roommates on 07/21/2025, the date of the above FRI. On 08/20/2025 at 3:25 PM, an observation was made of R102 in the dining/activity room of the unit he resides, he was sitting in his wheelchair watching TV, he appeared to be in a pleasant mood. He was asked if he minded if we went back to his room to talk privately, and he agreed. On 08/20/2025 at 3:27 PM An interview was conducted with R102 in his room, at which time he was asked if and what he could recall about the incident that occurred on 07/21/2025 with his old roommate R101. He reported that he remembered and then R102 stated, “I hit him”. R102 was asked if he hit R101 more than once and he replied, “I hit him three times”. R102 was asked what prompted you to hit R101 and his response was, “He (R101) was on my bed, he was calling me everything under the sun, he (R101) was waving the bible around saying, God and his son told me to tell you you’re a nigger”, and “I told him that’s not true”. R102 said, “I have a bible right there and it don’t say that. He (R101) told me that I must have the wrong book then”. R102 stated, “He (R101) raised the bible at me” and “I told him to stop and that I would whoop his ass if he didn’t”. R102 stated “he swatted it at me, so I hit him, I hit him three times and he fell”. R102 was asked what he hit R101 with, he replied, “the thing I use to put my shoes on” (confirmed as a shoehorn). R102 was asked, if R101 hit him or if he himself was injured and he responded, “Nah”. R102 was asked if he ever had any issues with R101 before this incident and he replied, “Everyday”. R102 was asked what the issues were, and he said, “He (R101) is always walking with and talking about the bible and said things that are not true” and “I don’t like that”. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	R102 was asked if he had ever asked to be moved to another room or change roommates because of this, his reply was “Everybody know how he (R101) is”. R102 was asked what he meant when he said, “how he (R101) is” and he responded, that “he (R101) walked the bible around and said things that were not true”. R102 continued, “I told them I was in Vietnam, and I can handle him”. R102 was asked specifically who he had told this to, and he said, “Everybody”. R102 was asked what was different on the day of the altercation and he stated, “He (R101) was on my bed, he would not get off it”, and that “He (R101) swatted the bible in my face”, and “He (R101) said God and his son said I am a nigger” and “I know that ain’t true; I don’t like that”. R102 was asked if he requested help from staff, he responded, “I am not sorry I hit him; I would do it again” and “I heard he (R101) is on (another) floor now”. He continued, “I have a bible right there” (R102 pointed at his bible on the stand) “That how I know he is wrong”. R102 was re-asked if he requested help from staff and he replied, “Didn’t need too”. On 08/20/2025 at ~3:37 PM, an interview with CNA “B”, when asked about R102’s demeanor and behaviors he stated, “I call him Mr. Smiley he is usually a happy guy, but if you make him mad then he will let you know”. On 08/21/2025 at 10:15 AM, an observation of R101 who was resting in his bed. Attempted to conduct and interview, an introduction was made and R101was asked if it would be ok if we talked. He said, “No, I do not want to talk”. R101 was then asked if we could talk later and R101 shook his head side to side, (indicating no). On 08/21/2025 at 10:17 AM, an interview with CNA “C” who had assigned care of R101, she was asked if she is familiar with the resident and she stated, “Yes, I have been taking care of him since he moved to my floor”. CNA “C” was asked, “why did he (R101) get moved?” and she stated, “He (R101) had an altercation with another resident”. CNA “C” was asked what she knew about that incident, and she stated, “He (R101) was hit on the head, got a cut and he went to the hospital for stitches”. CNA “C” was asked if R101 had any aggressive behaviors and she said, “No”. CNA “C” was asked if she had any knowledge of any additional incidents with R101 and she stated, “No, he is pretty much like you just saw, he is quiet, has a bible with him most of the time”. On 8/21/2025 at 10:51 AM, a phone interview was conducted with CNA “D”, who worked on the residents’ floor 07/21/2025. Asked if she could recall what happened on that date between R101 and R102. She reported, “I was working and was at the desk on the (floor on the incident) floor, When I saw (R101) came walking down the hall with blood all on his shirt, I did not know what was going on, I thought he had fallen” and I said, “oh my gosh (R101) what happened”. R101 said “He (R102) beat me, (R102) beat me with a club”. She continued, “So, I got up and grabbed a chair in the hallway, I sat him down and grabbed some towels and applied pressure, the other CNA (“CNA “F”) called out on the overhead for any nurse to come and assist”. CNA “D” was asked if she knew who or where the nurse working on that floor was and she stated, “I am not sure they don’t always wear name tags”, and “I think maybe she was passing medications”. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	She stated, “(R102) came out of the room, and he (R102) said, “I hit him (R101), I hit him with my shoe thing because he was in my bed”, and then “I (CNA “C”) told him (R102) you cannot hit people”. CNA “D” was asked if R102 was injured or did she see any injury and she stated, “I don’t think so”, but “both (R101 and R102) had blood on their clothes”. According to a record review of CNA “D’s” statement in the 5-day report: “I was sitting at the desk charting when (R101) was observed walking out of his room bleeding, stating “He beat me, I want to press charges” …, (R102) came out of the room shortly after with blood on his clothing. I asked him what happened, and he stated, “I told him to get out of my bed”.” On 08/21/2025 at 11:33 AM, during an Interview, the Administrator (NHA) stated that the facility had a unique and diverse set of residents ranging in age, demographics, medical diagnoses, trauma, and cognitive status at our facility and that can be challenging. The NHA was asked about the process and policy for determining roommate placement due to her stated diverse group of residents and she reported, the facility did not have a policy, and the placement process was done through gathering information from intake and hospital admissions. She stated, “we know our residents, and we consider demographics, progress notes, discharge needs and evaluate their placement, we are very good at that”, and “We use a bed board to track open beds”. The interdisciplinary team (IDT) team will review any issues. The NHA was asked if she assessed that R101 and R102 were an appropriate fit from this process, and she reported they had not had any problems in the past with each other. For clarification the NHA was asked and if either R101 or R102 had any previous issues from 07/21/2025 altercation regardless of it was with each other or separate and she stated, “R101 has had no other incidents, R102 has had a reportable (a prior altercation with staff or resident) about 6 months ago”. The NHA was asked about the extent of R101’s injuries as referenced both in the emergency room notes and the summary of incident when R101 returned to facility in the 5-day report as a laceration repair to scalp, a fractured right shoulder and a fractured right humerus with the summary of the incident in the 5-day report stated report of, “R101 rose abruptly… resulting in contact with the top of his head, which caused the laceration”, She was asked if the injuries sounded consistent she stated, “You can’t say that happened here”, asked for clarification on what that meant, she stated, “The shoulder and arm, that could have happened anywhere, in the ambulance or at the hospital, there is nothing in our notes saying that happened here”. The NHA was asked if he (R101) had a history of a fractured right arm before the incident and she again said it was not in their notes. The NHA was asked about the police involvement and if there was a report for the officer referenced in the 5-day investigation report and she said there were no charges pressed and that she had tried to get a copy of it but was told that there was no report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of F	G 3201 Beecher Rd Flint, MI 48532

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 - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the change of condition assessment for R101 under “functional status evaluation” revealed, “functional status change: general weakness” and “signs and symptoms: can ambulate independently”, and under the heading of “the skin assessment relevant to change in condition being reported: (on the body map) Area 1 is top of scalp laceration needing sutures; Area 17 right elbow with red/purple bruise new. Other …”. The assessment also revealed in “Pain status evaluation” indicated, “Rate pain…8 (was marked)”. (the pain scale of 0-10 was noted as 0 = no pain, 4-5 = moderate pain, 10 = excruciating pain) On 08/21/2025 at 1:15 PM, a voicemail was left for CNA “F” asked to return phone call about an investigation from an incident on 7/21/2025 at the facility. According to a record review of CNA “F’s” statement in the progress note provided by the DON stated, “I was standing at the nurses’ station, (R101) came out of his room, yelling help. I went to the resident and got a chair to sit him down and out (put) a towel on his head to stop the bleeding. I called the receptionist to have all (the) nurses to come to the floor. I stayed with the resident until nurses made it to him”. On 08/21/2025 at 1:17 PM, a voicemail was left for RN “G” asking for a return phone call about an investigation from an incident on 7/21/2025 at the facility. On 08/21/2025 at 1:47 PM, an interview was conducted with the Social Worker (SW) “E”, she was asked about IDT committee and what her role as the SW was in roommate placement and compatibility. She stat