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	12/11/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 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 the interview and record review, the facility failed to ensure that the resident's dignity and respect were maintained when the call light was not answered in a timely manner and incontinence care was delayed, causing the resident to lie on a soiled linen for one resident (Resident, #503 [R503]) of 3 residents reviewed for dignity and respect.Findings include: Resident #503 (R503):A review of the record revealed that Resident (R503) was alert oriented with a Brief Interview of Mental Status (BIMS) Score of 15/15 assessed on October 9, 2025. She was originally admitted to the facility on [DATE], with a diagnosis of type 2 diabetes, morbid obesity, absence of right leg above the knee and absence of left leg below the knee in addition to other diagnoses. She is dependent on staff care for transfers and the lower-body activitiesR503 was interviewed in her room on 12/10/25 at 3:32 PM. R503 stated that a few months ago, she reported that she was left lying in bed with poop for almost 4 hours. She continued to reveal that on Friday, dated 11/28/25, going into 11-2/25 in the morning, she was left again in her poop by a certain CNA G (Certified Nurse's Aide). R503 stated that she reported her concerns regarding a particular CNA, G, to the nurse because she did not want to perform ADLs (Activities of Daily Living) and neglected to change her; she ended up being changed in the morning. R503 continued to express that the same CNA (CNA G) has an attitude towards her and gave an example that when you press the call light for assistance, CNA G will respond and say, What do you want now? In a mean and harsh way. She made me feel like you are bothering her.' R503 explained that she is a bilateral lower extremity amputee and is experiencing severe pain and spasms, thus needs assistance with going to the bathroom. R503 described her phantom pain as unbearable while pointing at her left below-the-knee amputation (BKA). R503 admitted that she forgot whom she reported it to, but she did report it to nurses and staff at the facility the following shift, to the ombudsman, and to other caregivers. CNA G still works at the facility but no longer was assigned to her since she reported CNA G.Resident R503 also expressed that staff threatened or told her that if she calls 911, Against Medical Advice (AMA) or if the resident (R503) insists on calling 911 to go to the hospital, she will not be accepted or re-admitted back to the facility.The Director of Nursing (DON) during an interview on 12/11/25 at 12:30 PM denied knowledge about the allegation and will start an investigation regarding R503's allegations. The DON stated that she was aware the CNA was not assigned to the second floor but denied knowing the reason for not assigning her to 2nd floor.An interview with the 2nd Floor Charge Nurse E was conducted on 12/11/25 at 1:20 PM. Charge Nurse E stated that she remembered the conversation with R503, where she reported the CNA leaving her for prolonged periods until the next shift. The CNA (identified the name) reported is no longer assigned to work on the second floor. We removed the staff sometime at the end of November when the incident was reported, and she's no longer assigned to the second floor starting in December. I did not report the incident to the DON, but because the schedule was implemented for the CNA who was not assigned to her, I assumed the DON was aware of the situation. When the charge nurse was asked what and when the incident occurred, she stated that R503 was left soiled for prolonged periods by a certain CNA and that it was not cleaned until the next shift. It happened sometime at the end of November. The charge nurse stated it happened during the weekend, and she was not working that weekend. The DON was aware because she was taken off the floor. R503 was worried about a right shoulder Cellulitis that she was sent out for due to severe pain in her shoulder. When we explained all the testing, the nurse practitioner did so, and she agreed to stay, but we did not threaten her with AMA status or readmission. She decided to stay, and the practitioner ordered pain medication and a Doppler for the right shoulder.Regarding call light response, R503 expects her to respond right away. She is now care planned to have 2-person assistance and careAn Outside Agency B witnessed the resident sometime in September 2025. She was interviewed on 12/11/25 at 12:54 PM. The Outside Agency B stated she witnessed the resident lying on a bed on a linen saturated with urine. But the nursing staff put a dry pad on top of it. When the staff were asked, they stated there was a linen shortage and that they were waiting for the laundry to deliver clean linen. The Outside Agency B discussed these findings at that time, but the laundry came up the elevator with clean sheets. The Outside Agency B stated that R503 complained about the delayed response time for the call light, the staff not providing care, and leaving her soiled for a prolonged period.Agency Visitor C during a phone interview conducted on 12/11/25 at 12:34 PM stated that there were 2 outside agency visitors that were present at the facility, and witnessed that she was soiled, and despite the call light, she was sitting on it for over 40 minutes, and no staff went into her room