

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/30/2025
NAME OF PROVIDER OR SUPPLIER Mission Point Nursing & Physical Rehab Center of F		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2698598. Based on interview and record review, the facility failed to notify a responsible party of a change in condition for one resident (R1) of three residents reviewed for change in condition, resulting in the responsible party not being informed of a wound developing and being started on an antibiotic. Findings include: R1 is [AGE] years old and admitted most recently to the facility on [DATE], he originally admitted on [DATE], with diagnoses that include cellulitis of the right and left lower leg, adult failure to thrive, peripheral vascular disease and local infection of the skin and subcutaneous tissue. On 12/26/25 at 01:00pm, record review of the electronic medical record EMR revealed that R1 had developed a new wound on his left foot on 12/04/25 and had started taking antibiotics for a wound infection on 12/18/25. There was no documentation present that the family was notified of either of these changes. On 12/26/25 at 01:31pm, an interview was conducted with the wound care nurse B. Wound Care Nurse B is also the Unit Manager for the 3rd floor where R1's room was located. Wound care B was asked if a resident has developed a new wound or was started on an antibiotic would you notify the responsible parties and document it. Wound Care B replied it would typically be in my rounds, but there is no documentation for any notification I can find for R1. If a resident was started on an antibiotic that would be documented in the chart. Wound Care B was asked why these items were missed. Wound Care B replied it was just an oversight. On 12/26/25 at 02:00pm an interview was conducted with the daughter of R1. The daughter was asked if she was aware of any changes with her father recently? The daughter replied, no, not really. I was not aware of the wound on his buttocks, and I questioned it when I was last in the facility. Were you aware of the new wound on his left foot? I was not made immediately aware of the wound on his left foot. Were you aware that on 12/18/25 R1 was started on an antibiotic for one of his wounds? The daughter replied, no, the nursing home did not notify me. The daughter was asked, if she thought the facility did a good job of keeping her informed? The daughter replied, in some ways they kept me involved but other ways they didn't. I was unaware that he had sustained a fall a while back and I was not informed of this new wound on his buttocks or foot, I was also not aware he was started on an antibiotic. A review of the policy titled, Change in a Resident's Condition or Status, revealed: Policy Statement Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Policy Interpretation and Implementation: 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: b. There is a significant change in the resident's physical, mental, or psychosocial status. d. A need to alter treatment significantly (a need to discontinue or change an existing form of treatment due to adverse consequences, or to commence a new form of treatment.</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 235363
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise care plans for skin integrity for one resident (R1) of three residents reviewed for care plans, resulting in skin integrity care plans that did not accurately reflect the current condition of the resident. Findings include:R1 is [AGE] years old and admitted most recently to the facility on [DATE], he originally admitted on [DATE], with diagnoses that include cellulitis of the right and left lower leg, adult failure to thrive, peripheral vascular disease and local infection of the skin and subcutaneous tissue.On 12/26/25 at 11:00am, record review of the Electronic Medical Record EMR for R1 revealed that R1 had wounds on his:-Right dorsal foot, identified 5/7/25.-Left dorsal foot, identified 12/17/25.-Left proximal lower leg, identified 12/10/25.-Left lower leg anterior, identified 10/01/25-Left buttocks, identified 11/19/25.On 12/26/25 at 11:15am, record review of the EMR revealed a care plan titled, I have actual impairment to skin integrity r/t, hidradenitis suppurativa, MASD left ischium, resident has worsening HS to right foot. Date initiated, 01/30/2022. A review of the care plan history revealed this care plan was last revised on 5/7/25.On 12/26/25 at 01:52pm, an interview was conducted with wound care B. Wound Care B was asked who is responsible for updating care plans for skin integrity. Wound care B stated, I can update them, the nurses on the floor can update them or the Minimum Data Set MDS nurse can update them as well. Wound care B was asked if the care plan for R1 should have been updated with his new wounds. Yes, they should have been updated. This one must have been missed. This surveyor verified that the actual skin integrity care plan for R1 had not been updated since 5/7/25 even though there had been four wounds identified since then.Review of the policy titled, Careplan Standard Guideline, revealed:Procedure:6. The care plan is to be revised to reflect the current status of the resident.7. The care plan will be reviewed throughout the resident's stay upon admission, quarterly and with changes in condition.8. The care plans will be reviewed and revised at the care conference in collaboration with the resident and/or resident representative.</p>		