STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235405	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	17001 17 Mile Road Clinton Township, MI 48038

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 0602 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: 2684900,2686660,2687810, and 2689521.Based on observation, interview, and record review, the facility failed to prevent financial exploitation for one resident (R700) out of two reviewed for misappropriation of funds, resulting in mental anguish and emotional distress. Findings include:A review of a Facility Reported Incident (FRI) noted the following, . Findings: Misappropriation of Resident Funds, Substantiated Psychological abuse, Substantiated Conclusion: An investigation was initiated on 11/25/2025 after [R700] reported concerns involving the Business Office Manager, [Business Office Manager (BOM) B. Through multiple interviews and review of documentation and phone messages voluntarily presented by the resident, the facility identified information suggestive of financial exploitation, misappropriation of resident funds, and violations of professional boundaries. As [R700] is under full guardianship and legally incapacitated, [R700] does not have the authority to consent to financial transactions or personal interactions of an intimate or influential nature with staff. Transfers of funds to the employee occurred without guardian authorization, and resident trust funds were moved without required oversight.A review of the medical record revealed R700 re-admitted into the facility on 8/1/2025 with the following medical diagnoses, Anxiety disorder, Bi-Polar, Narcissistic Personality disorder, and adjustment disorder. A review of the most recent Minimum Data Assessment set revealed a Brief Interview for Mental Status score of 15/15, indicating an intact cognition. R700 also required staff assistance with bed mobility and transfers.Further review of the medical record revealed the following progress notes, Date:11/26/2025.Description of what occurred: Patient observed to have increased anxiety, paranoid, lack of sleep, and suicidal ideation. Staff member had unprofessional conduct with resident. Employee suspended, psych (psychiatry) to F/U (follow up), like resident interviews held, psychosocial assessments, police report, pain and skin assessments.Immediate intervention implemented 1:1 monitoring, behavior progress notes, psych to eval (evaluate) and treat. Date:11/26/2025.Resident observed with (2) open areas proximal L (Left) wrist. Open areas #1 and #2 observed small amount of bleeding. Open areas #1 approximate measurement 2.0cm (centimeters) x 0.1cm. Open area #2 approximate measurement 3.0 cm x 0.1cm .New orders received to transfer to ER (Emergency Room) at [Hospital] for psychiatric assessment R/T (Related To) attempting self-harm with suicidal ideations.A review of the inpatient psychiatry note dated 11/26/2025 noted the following, Patient presented to the ED (Emergency Department) via ambulance for hypoxia (shortness of breath) and suicidal ideation. Patient resides at an ECF (Extended Care Facility) and reportedly has been on 1:1 for agitation. Patient made suicidal statements today,,.per staff. Patient reports [they] had multiple blades from razors stored. Leaving one in the bed which [they] reports [they] rolled over and cut [their] left wrist .Patient became more uncooperative after a staff member was terminated for having an inappropriate relationship with patient. On 12/10/2025 at 10:18 AM, an interview was conducted with R700. R700 was noted to have a 1:1 sitter in the room with them. R700 reported that they were not financially exploited by BOM B. R700 reported the Nursing Home Administrator (NHA) is upset they can not control them and that they believe the NHA stole all their money. R700 reported that BOM B is the only person in the facility that cares about me and helps me. R700 reported that BOM B did have control over their money but would buy them items such as Dr. Pepper and bathroom items. R700 was asked about their suicide attempt and reported that it was an accident. R700 reported they slipped and fell on a razor and did not need a 1:1 sitter anymore.On 12/10/2025 at 10:40 AM, an interview was conducted with Certified Nursing Assistant (CNA) C. CNA C was the current 1:1 sitter for R700. CNA C reported R700 had a 1:1 sitter for all shifts and that they usually work midnights. CNA C reported that R700 has named a teddy bear after BOM B, and they are distraught over BOM B no longer working in the facility.On 12/10/2025 at 10:49 AM, an interview was conducted with the Legal Guardian (LG) D for R700. LG D reported they were informed by the facility that an employee was misusing R700's funds and entered into an inappropriate relationship with them. LG D reported R700 has a debit card that they provided for them and puts funds on there for R700. LG D reported they were informed by the facility that another debit card was opened for R700 and the funds from their resident trust fund were transferred there without their consent. LG D reported they were sending approximately $1800 per month because they thought R700 had a patient pay amount and was not informed that R700 did not have to send any money to the facility, so the money was being put into a resident trust fund that was being managed by the facilities BOM B. LG D reported BOM B did call their office and ask could the funds be used to obtain dentures for