

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235624	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Portagepointe		STREET ADDRESS, CITY, STATE, ZIP CODE 500 Campus Drive Hancock, MI 49930	
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. This deficiency pertains to Intake #2673210Based on interview and record review, the facility failed to protect the rights of five Residents (#2, #3, #4, #30, & #62) of five residents reviewed for abuse to be free from abuse by a staff member. This deficient practice resulted in feelings of fear, intimidation, frustration, and/or pain for Resident #3, Resident ^#4, and Resident #30.Findings include:The facility submitted a Facility Reported Incident (FRI) to the State Survey Agency on 11/7/25 after four Certified Nurse Aides (CNAs) independently reported concerns regarding the care provided by CNA B. The allegations described a recurring pattern of neglectful care and resident mistreatment and included rough physical handling of residents, failure to provide bathing and showering, prolonged failure to respond to resident call lights, extended absences from the assigned work area resulting in delayed care, failure to cleanse residents following bowel movements, and the use of inappropriate transfer techniques. The FRI identified Resident #2 (R2), Resident #4 (R4), Resident #30 (R30) and Resident #62 (R62) as residents affected by the alleged abuse and documented CNA B had previously been suspended following an allegation of elder abuse.The facility's investigative findings concluded the allegations were substantiated. The investigation documented multiple residents consistently demonstrated agitation, fear, or emotional distress when CNA B was assigned to provide their care and determined there was an identifiable pattern of elder neglect and mistreatment. The facility investigation findings read, in part: .the facility identifies a pattern of concerns. It is identified that multiple elders [residents] in [name of facility unit redacted] don't respond in a positive way when [CNA B] is working, they become agitated or upset when he is caring for them. Facility has completed full investigation and SUBSTANTIATES/VERIFIES [sic] elder NEGLECT [sic] and MISTREATMENT [sic] by [CNA B].During the survey, independent interviews with four CNAs who worked directly with CNA B revealed consistent, mutually corroborative accounts describing rough resident handling, failure to provide necessary care, refusal to honor resident requests, disregard for resident dignity, delayed responses to resident needs, and abusive interactions that caused observable pain, fear, and emotional distress. Although each CNA described separate incidents occurring over different periods of time, their statements demonstrated a consistent pattern of conduct involving multiple residents. Each CNA described separate incidents and their statements demonstrated a consistent pattern of conduct involving multiple residents.During an interview on 7/22/26 at 9:00 AM, CNA F described observing R3 confined on a commode while repeatedly pleading to be assisted off the toilet. After hearing R3 loudly state, I want to get out, let me up, CNA F entered the bathroom and observed CNA B holding a cellular telephone in one hand and holding down R3 on the commode with the other hand. CNA F completed the resident's toileting care after intervening. CNA F further reported witnessing CNA B refuse R30's request to wear a T-shirt, telling the resident he would wear a gown because it was easier, despite the resident's expressed preference. After CNA F (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 0600 Level of Harm - Actual harm Residents Affected - Few	honored R30's request, the resident appeared relieved and thankful. CNA F additionally described assisting CNA B with toileting R62, during which CNA B attempted to pull the resident's clothing up after a bowel movement without cleansing the resident. CNA F intervened to provide the required perineal care because CNA B didn't want to be bothered cleaning the resident. CNA F further reported repeatedly observing residents request assistance or care that CNA B either ignored or refused to provide. On 7/22/26 at 10:58 AM, CNA G similarly described repeated failures by CNA B to provide required care. While monitoring R3 through an auditory resident monitoring device, CNA G heard R3 repeatedly request assistance to use the bathroom and heard CNA B tell the resident he was not taking her to the bathroom. CNA G also reported R2 disclosed CNA B handled him roughly and man-handled him during care, a concern she reported to the Nursing Home Administrator (NHA). CNA G further described persistent failures by CNA B to respond to resident call lights, requiring other staff members to routinely assume responsibility for CNA B's assigned residents to ensure essential care needs were met. CNA C was interviewed on 7/22/26 at 12:02 PM. CNA C described CNA B as consistently rude, abrupt, and inappropriate in his interactions with residents. CNA C reported repeatedly observing CNA B forcefully push R30's contracted lower extremities onto a positioning wedge despite the resident screaming in pain and pleading for him to stop. According to CNA C, CNA B continued despite the resident's obvious discomfort. Following these incidents, CNA C said R30 became fearful other caregivers would similarly force his legs during care and repeatedly requested staff not push on his contracted extremities because he feared they would hurt him. CNA C additionally described CNA B refusing resident requests for assistance, including denying a resident's request for food while remaining seated using his cellular telephone, and routinely ignoring resident call lights. On 7/22/26 at 2:17 PM, CNA H independently corroborated CNA C's observations involving R30, describing the resident as being in obvious pain when CNA B forcefully manipulated his contracted lower extremities. CNA H reported R30 described CNA B as rough and abusive and characterized CNA B's interactions with residents as lacking compassion and patience. CNA H further witnessed CNA B transfer R4 by lifting the resident from a wheelchair and throwing him onto the bed despite the resident requiring a mechanical sit-to-stand lift for safe transfers. Although R4 was largely nonverbal because of cognitive impairment, CNA H observed what he described as obvious fear and terror in the resident's facial expressions during the transfer. CNA B did not respond to the surveyor's request for an interview. However, the facility's investigation documented an interview conducted on 11/10/25 during which CNA B admitted failing to cleanse R62 following a bowel movement while denying the remaining allegations. CNA B attributed his conduct to stress and distraction. On 7/23/26 at 8:47 AM, the NHA subsequently reported CNA B asserted during the interview, he could no longer provide appropriate resident care and attempted to voluntarily resign during the investigation. The facility rejected the resignation and immediately terminated his employment after concluding the allegations of neglect and mistreatment were substantiated. The NHA further stated the investigation determined CNA B's actions represented a willful, patterned, and conscious course of conduct. The NHA conveyed she was told by CNA B during questioning that he was burned out. Review of the medical records of R2, R3, R4, R30, R62 revealed that despite substantiating abuse involving multiple residents, the facility failed to conduct a comprehensive post-incident assessments to determine the full extent of resident harm. Record review failed to identify timely head-to-toe skin or injury assessments for the affected residents following the initial abuse allegations on 11/7/25. The only subsequent physical finding identified was a skin assessment completed for R62 on 11/12/25 documenting new bruising of the upper outer arm that had not been present during the previous assessment conducted on 11/5/25. Additionally, the facility failed to (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	complete psychosocial or trauma assessments, initiate supportive interventions, revise resident care plans, increase monitoring, or implement individualized measures to address the physical and emotional impact of the substantiated abuse. These omissions persisted despite the facility's own determination that multiple residents had been subjected to a repeated pattern of abuse, neglect, and mistreatment. The policy titled LTC Breach of Elder's Rights dated as last revised 5/13/26 read, in part: . Abuse: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish (includes the deprivation by an individual, including a caretaker, of goods or services necessary to attain or maintain physical, mental and psychosocial well being). Mistreatment: Means to handle an Elder roughly or wrongly. Neglect: The failure of the facility, it's employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. This home will not condone abuse of any type by anyone including staff members. The policy titled LTC Suspicion of Abuse Protocol dated as last revised 5/13/26 read, in part: . Perform a thorough nursing physical examination. Following any abuse allegation, Elders will be assessed for psychosocial harm by the Social Worker/ Social Work Designee. If found, appropriate interventions and care plan updates will be put in place for the Elder. Document the Elder interview and assessment in the nursing notes.		